ARIZONA

DEPARTMENT OF ADMINISTRATION

BENEFITS

HEALTH INSURANCE TRUST FUND ANNUAL REPORT 2019

FOREWORD

The Arizona Department of Administration ("ADOA") offers health, dental, life, and disability insurance as well as medical and dependent care flexible spending accounts to the State of Arizona ("State") Active employees, COBRA members, and Retirees. This combined group of benefits offered is referred to as Benefit Options. This report provides a broad overview of the Benefit Options program and meets the requirements of the A.R.S. §38-652 (G) and A.R.S. §38-658 (B).

The data shown is presented for January 1, 2019, through December 31, 2019. The Active and Retiree plans were concurrent for this period.

Any questions relating to the contents of this report should be addressed to:

Arizona Department of Administration
Benefit Services Division
100 N. 15th Avenue, Suite 260
Phoenix, Arizona 85007

Telephone: 602-542-5008

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Report Background

This document reports the financial status of the Employee Health Insurance Trust Fund (HITF) pursuant to A.R.S. §38-652 (G), which reads:

"The Department of Administration shall annually report the financial status of the trust account to officers and employees who have paid premiums under one of the insurance plans from which monies were received for deposit in the trust account since the inception of the health and accident coverage program or since submission of the last such report, whichever is later."

The Annual Report also reports the performance standards for the health plans pursuant to A.R.S. §38-658 (B), which reads:

"On or before October 1 of each year, the Director of the Department of Administration shall report to the Joint Legislative Budget Committee on the performance standards of health plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations."

Benefit Services Division accounts for the Benefit Options program in two different funds. The Special Employee Health Insurance Fund, also known as Fund 3015 or the Health Insurance Trust Fund, encompasses the medical and dental programs and the appropriated expenditures for the Arizona Department of Administration (ADOA), Benefit Services Division operations. The Employee Related Expenditures (ERE)/Benefits Administration Fund, or Fund 3035, is primarily a pass-through fund for other benefits, including vision, life, and disability insurance, as well as flexible spending accounts.

The benefits offered are either self-insured or fully insured. For plan year (PY) 2019, all medical, except for the Northern Arizona University (NAU) Blue Cross Blue Shield of Arizona (BCBS) fully insured plans and Dental Preferred Provider Organizations (PPO) plans, were self-insured, whereas the Dental Health Maintenance Organization (HMO), vision, life, and disability insurance plans were fully insured.

The State's medical plan became self-insured on October 1, 2004. The current set of contracts runs from July 15, 2014, through December 31, 2019, with an extension granted through December 31, 2020. The State contracts with the medical and pharmacy vendors to provide network access and related discounts, claim adjudication and payment, and medical management, including utilization management, case management, and disease management. The State is responsible for the full cost of all claims and programs offered by the vendors.

The State's self-insured dental PPO began on January 1, 2013.

Schedules of premiums received and accounted for in Fund 3015, distributions by enrollments, incurred and paid medical/drug claims, and expenses related to the medical and dental plans, are included within this Annual Report. Also included is a summary of premiums collected and paid

for the life insurance, disability insurance, vision insurance, and flexible spending accounts for Fund 3035.

All data provided herein is for Plan Year ("PY") 2019 running January 1, 2019, through December 31, 2019.

Please note: statistics will vary from previous annual reports due to the late receipt of program data following the completion of the previous annual report. Further, the Benefit Services Division has moved to using a new data-mining platform called MedInsight to extract data, which further explains some of the variances in reported statistics. In no case does the variation represent a substantive change in trend. Last, some schedules represent a hybrid of cash and incurred accounting methods.

Executive Summary

During PY 2019, ADOA offered a comprehensive insurance package through Benefit Options to approximately 136,500 members consisting of Active State and University employees, COBRA members, Retirees and their qualified dependents. This figure excludes the 5,700 members that are served through the NAU BCBS fully insured programs. The benefits offered in the package include medical, pharmaceutical, dental, flexible spending, vision, wellness, an employee assistance program (EAP), life, and disability insurance.

During PY 2019, the sum of health and dental premiums collected was $869.3M with total plan expenses, including transfers, of $895.6M. Reported expenses include claims incurred in 2019 and prior plan years' claims paid in PY 2019 and transfers out to other State funds (Figure 2).

Claims figures, referred to below, apply to 2019 incurred claims only, regardless of paid dates. Any figure that includes administrative and operating costs is a hybrid of two accounting methods as the administrative and operating costs are recorded on a cash basis while the claims costs are retrieved on an incurred basis from the MedInsight claims system.

Health Plan

- The average annual plan expense, including claims, administrative costs, and fees per member was $5,940.
- The average Active member expense was $5,740; the average Retiree member expense was $9,360.
- The PY 2019 medical claims expenses totaled $591.8M, excluding Incurred But Not Reported (IBNR) liability (Figures 7 and 8). This figure was retrieved from the MedInsight claims system using incurred claim dates between January 1, 2019, and December 31, 2019. This differs from the $601.3M number in Figure 2 that represents medical claims expenses paid out of the Arizona Financial Information System (AFIS) during PY 2019 regardless of incurred dates (cash basis accounting). Therefore the $601.3 figure includes claims with incurred dates between January 1, 2019, and December 31, 2019 (PY 2019 claims) and claims submitted to ADOA for reimbursement during PY 2019 but with incurred dates prior to PY 2019. The AFIS figure also includes

any other claims expenditure related transactions such as adjustments and corrections for overpayments, coding errors, subrogation transactions, pharmacy rebates submitted by the medical vendors, wellness expenses such as flu shots and screening costs.

- In terms of total medical claims spend, the Health Status and Contact with Health Service group takes the lead at almost 12.8% of total medical claims spend. However, medical and health professionals do not consider this a single major diagnostic group. Rather, this category represents a roll-up of claims with specific diagnosis codes covering regular primary care physician visits, including OB/GYN, preventative services such as wellness (well-baby and well-child visits, routine vaccinations, screenings, and tests) and other specialist visits. Therefore the actual single leading diagnosis group by total medical claims spend is the Musculoskeletal System and Connective Tissue category at 12.1% (or $71.4M) of total medical claims spend.
- The fact that the top medical claims spend is occurring in the Health Status and Contact with Health Service group (primary care) indicates that members are seeking appropriate levels of care by obtaining the majority of care from physicians or specialists. The Health Affairs journal, the leading journal on health policy thought on health reform, health care costs, and health systems innovation, published a study in May 2010 called "Primary Care and Why It Matters for U. S. Health System Reform". In this study, the authors Robert L. Phillips and Andrew W. Bazemore quote that the United States' primary care spend represents 10-12% of total healthcare spending. The 13.1% figure attributed to primary care spent on our plan compares favorably to this study.
- 3,664 physician visits per 1,000 members (lower than prior year's revised figure of 3,717).
- 184 urgent care visits per 1,000 members (notably higher than the prior year's revised figure of 171).
- 189 emergency room visits per 1,000 members (marginally higher than the prior year's revised figure of 187).
- The PY 2019 pharmacy claims expense was $199.8M (Figures 7 and 8). This represents pharmacy claims paid by vendors with incurred claim dates between January 1, 2019, and December 31, 2019, and paid dates through March 2020. Pharmacy rebates and Medicare Part B Retiree Drug subsidies are not included in this figure, as the MedInsight system does not capture this information. This differs from the $197.5M number in Figure 2 that represents pharmacy claims expenses paid out of AFIS during PY 2019. This figure represents claims with incurred dates PY 2019 and prior plan years' pharmacy claims. This figure includes any other expenditure-related transactions such as adjustments and corrections and excludes Medicare Part B Retiree Drug subsidies and pharmacy rebates.
- The leading therapeutic drug class by cost was anti-diabetics at close to 14.3% of total pharmaceutical spend.
- Over 1.3 million prescriptions were filled in PY 2019.
- Active employees filled an average of 8.4 prescriptions per year, while Retirees filled an average of 27.0. Those figures remain mostly unchanged from PY 2018.

Wellness Program

- Administered over 15,237 flu vaccines through 570 worksite or public events.

- Administered over 10,969 screenings through 242 statewide worksite events resulting in 773 referrals to physicians for various health issues. This represents a slight increase in referrals over the prior year, with the majority of referrals coming from Diabetes screening.
- Incentives covering 5,479 employees participating in the Health Incentive Program (HIP) program during PY 2019 were paid out during the spring of calendar year 2020. The incentives total $1,090,400 representing a 26% increase over the PY 2018 incurred figure paid out in PY 2019.

Performance Measures

Financial guarantees are in place to manage the performance of the contracted vendors. Most vendors met the majority, or all, of the agreed-upon performance measures. However, estimated penalties of approximately $532K will be collected in calendar year 2020 from vendors failing to meet agreed-upon PY 2019 performance targets in customer service, claims processing, appeals, reporting, surveys, and network management. During calendar year 2019, $130k of performance penalties were collected related to the PY 2018 performance period.

Health Insurance Trust Fund Review and Summary

Total PY 2019 expenses, including 2019 and prior PY claims, were covered by revenues collected during 2019 and the cash balance from the prior year.

The Health Insurance Trust Fund Summary (Figure 2) is a cash statement of receipts received and expenses paid during PY 2019 that relate to PY 2019 as well as prior plan years.

ADOA Health Plan is a self-insured medical program that includes Aetna Life Insurance Company (Aetna), Blue Cross Blue Shield of Arizona (BCBS), Cigna Health and Life Insurance Company (Cigna), and United HealthCare Services, Inc. (UHC) networks. State and University Active employees and Retirees choose coverage from one of the self-insured networks.

NAU Active and COBRA members have an additional option to participate in the fully insured BCBS NAU plans (PPO and HSA). The plans are managed by the university, and the ADOA serves as a pass-through entity between NAU and BCBS. Practically speaking, premiums collected by NAU are passed on to ADOA every month. Those premiums are then submitted to BCBS via payment of the monthly premium invoice the following month.

The PY 2019 final rates for the 07/01/2019 – 12/31/2019 timeframe are provided below for comparison between the self-insured PPO plan and fully insured BCBS PPO plan. These rates are based on a bi-weekly payroll calendar with 26 pay periods per year.

Active Medical Premiums per Pay Period (26 pay periods)*				
Plan	**Tier**	**Employee Premium**	**State Premium**	**Total Premium**
State of AZ Self-Insured PPO (Aetna, BCBS, UHC)	Employee only	$53.34	$273.30	$326.64
	Employee + adult	$112.43	$577.89	$690.32
	Employee + child	$75.30	$386.73	$462.03
	Family	$131.25	$674.20	$805.45
NAU BCBS Fully-Insured PPO	Employee only	$38.83	$298.83	$337.66
	Employee + adult	$107.78	$601.31	$709.09
	Employee + child	$76.98	$429.51	$506.49
	Family	$161.37	$750.31	$911.68

Figure 1: Active Medical Premiums per Pay Period (26 pay periods)

For additional information regarding the differences between the two PPO plans, please visit the NAU Human Resources website.

The pharmacy benefits management for all members is provided by MedImpact Healthcare Systems, Inc. The pharmacy offers a three-tier formulary for a 31-day supply of medication, with

a $15 copay for generic drugs, $40 copay for preferred brands, and a $60 copay for non-preferred brands.

ADOA dental plan services were provided by two vendors during PY 2019: Delta Dental Plan of Arizona (Delta Dental) and Cigna Health and Life Insurance Company (Cigna Dental).

The schedule below represents the HITF Change in Fund Balance Statement for PY 2019. The Benefit Services Division accounts for the HITF on a cash basis, as a result incurred but not reported claims are not considered in our statement. Commercial standards typically require a two month reserve balance. The Division believes that sufficient resources would be made available to cover any insufficiencies that may develop, such as an actual medical trend exceeding the projected medical trend, unplanned shifts in plan membership, unexpected catastrophic claims, and changes in provider reimbursement rates that may occur during each plan year.

Plan Year 2019	
Beginning Fund Balance January 01, 2019	**$109,909,504**
Revenues	
ADOA Benefit Options	$781,344,548
BCBS (NAU)	41,409,158
ADOA Dental Plan	42,635,577
PrePaid Dental Plan	3,904,669
Other Revenue	49,301
Total Revenues	**$869,343,252**
Expenditures	
Administrative Fees	$29,774,505
Medical Claims	601,299,456
Drug Claims	151,766,092
Dental Claims	38,359,380
Medicare Part D Retiree Drug Subsidy	23,662,207
BCBS (NAU) Premiums	41,468,516
Fully Insured Dental Premiums	3,877,304
Appropriated Expenses	5,349,487
Administrative/Cash Adjustments	44,913
Fund Transfers Out *	2,636
Total Expenditures and Transfers	**$895,604,494**
Ending Fund Balance December 31, 2019	**$83,648,262**

* Fund transfers from HITF to other State funds.

Figure 2: Health Insurance Trust Fund Summary

Medical Plan Enrollment

Benefit Services Division offers medical coverage to the following employees and their dependents:

- Eligible state employees and university staff, officers, and elected officials
- State Retirees receiving pension benefits through any of the State retirement systems
- State employees or university staff accepted for long-term disability benefits
- State employees or university staff, including dependents, eligible for COBRA benefits

The three types of medical plans offered to eligible participants are the Exclusive Provider Organization (EPO), the Preferred Provider Organization (PPO), and the High Deductible Health Plan (HDHP) with Health Savings Account (HSA).

The EPO Plan
Within the EPO plan, services must be obtained from an in-network provider; out-of-network services are only covered if pre-authorized or in emergencies. An exception applies in situations, where a network provider is not available within a certain radius of the member. The employee pays the monthly premium and any required copay at the time of service. Employees who select the EPO plan may choose from four networks: Aetna, BCBS, Cigna, or UHC. Starting in PY 2019, members on the EPO had to satisfy a deductible of $100 for employee only or $200 per family.

The PPO Plan
Within the PPO plan, services may be obtained from an in- or out-of-network provider. There are separate in- and out-of-network deductibles that must be met before copays or coinsurance (percent of the cost) are allowed. The employee pays the monthly premium, and at the time of service, pays 100% of the allowed amount of the service until the deductible is met. After the deductible is met, the employee pays a copay if the provider is in-network and coinsurance if the provider is out-of-network, until the out-of-pocket maximum (OOP) is met. Once the OOP is met, the plan pays 100% of services for the remaining plan year, with a few exceptions, e.g., pharmacy copays. Employees who select the PPO plan may choose from three networks: Aetna, BCBS, or UHC. Employees at NAU also have the option of participating in their fully insured BCBS NAU plan.

The HDHP with HSA Plan
Within the HDHP, services may be obtained from both in- and out-of-network providers. Separate in- and out-of-network deductibles must be met before coinsurance is allowed. The employee pays the monthly premium, and at the time of service, pays 100% of the allowed amount of the service (except for qualified preventative services that are covered 100% by the plan), until the deductibles are met. After the deductibles are met, the employee pays coinsurance up to the out of pocket maximum, at which time the plan pays 100% of any additional costs for the year.

Employees who enroll in the HDHP and are under the age of 65 are eligible to open an HSA. This account allows employees to make pre-tax contributions into the account and withdraw the monies to pay for qualified medical expenses. When the employee opens the HSA with the State HDHP, the State also contributes bi-weekly to the account. The annual amount that the State contributes towards the HSA is $720 for employee/single tier only and $1,440 for all other tiers. Employee contributions to the HSA are not mandatory. The HDHP is only available to Active employees and only under the Aetna network.

Figure 3 below shows enrollment distribution by plan and network between Active, Retired, University, and COBRA members. The subscriber references the employee and the member references the employee plus dependents.

Average Monthly Medical Enrollment by Plan & Network					
		2019		2018	
Network	Plan Type	Subscribers	Members	Subscribers	Members
Active	EPO	1,845	3,989	1,842	4,065
Retiree	EPO	231	303	245	320
University	EPO	2,217	4,302	2,187	4,258
COBRA	EPO	18	30	19	33
Active	PPO	458	1,098	361	853
Retiree	PPO	21	25	23	27
University	PPO	527	1,147	427	939
COBRA	PPO	8	15	4	7
Active	HDHP	2,229	5,136	1,642	3,834
Retiree	HDHP	0	0	0	0
University	HDHP	1,419	3,063	1,172	2,511
COBRA	HDHP	22	56	17	33
Total AETNA		**8,994**	**19,164**	**7,939**	**16,880**
Active	EPO	7,495	18,044	7,636	18,668
Retiree	EPO	1,153	1,558	1,190	1,611
University	EPO	4,386	9,021	4,158	8,680
COBRA	EPO	35	61	46	73
Active	PPO	1,773	4,323	1,493	3,625
Retiree	PPO	74	97	74	93
University	PPO	1,603	3,753	1,249	2,945
COBRA	PPO	29	52	22	43
Total Blue Cross Blue Shield AZ		**16,548**	**36,909**	**15,868**	**35,738**
Active	EPO	2,614	6,289	2,821	6,883
Retiree	EPO	544	722	564	752
University	EPO	1,359	2,937	1,420	3,058
COBRA	EPO	17	26	16	21
Total CIGNA		**4,533**	**9,974**	**4,821**	**10,714**
Active	EPO	14,916	36,236	16,240	39,637
Retiree	EPO	4,359	5,724	4,727	6,231
University	EPO	9,287	21,085	9,622	22,021
COBRA	EPO	74	135	83	129
Active	PPO	1,630	4,052	1,428	3,472
Retiree	PPO	96	128	96	126
University	PPO	1,347	3,099	1,208	2,717
COBRA	PPO	23	41	19	29
Total UnitedHealthcare		**31,732**	**70,500**	**33,422**	**74,362**
NAU Active	PPO	2,484	5,352	2,526	5,420
NAU Retiree	PPO	286	391	283	387
Total Blue Cross Blue Shield NAU		**2,770**	**5,743**	**2,809**	**5,807**
Total		**64,577**	**142,290**	**64,859**	**143,501**

Figure 3: Average Monthly Enrollment by Plan and Network

Medical Premiums

The tables below show the medical premium by plan and coverage tier per pay period for Active employees and Retirees. Retirees have two different tier structures: 1) those who are not enrolled in Medicare and have no dependents enrolled in Medicare and 2) those who are either enrolled in Medicare themselves or have a dependent who is enrolled in Medicare.

To alleviate the decreasing HITF cash balance, the Legislature started infusing the HITF with annual one-time General Fund (GF) infusions starting in FY 2018. The one-time infusions were put in place as State (employer or ER) medical premium increases. Each GF infusion is matched with various other and federal fund sources at roughly a 1:2 ratio, meaning each GF dollar will generate $2 of other and federal revenue. The latest FY 2020 medical premium infusion is estimated to generate $34.4M as compared to base FY 2017. Retiree medical premium increases can only be approved via the annual Contribution Strategy document and can take place anytime. However, when changes have been implemented in the past, they always occurred at the beginning of each plan year (PY).

Active rates effective 01/01/2019 through 06/30/2019 (last two quarters of FY 2019) based on a bi-weekly (26 pay periods per year) calendar:

Active Medical Premiums per Pay Period (26 pay periods)*					
Plan	Tier	Employee Premium	State Premium	Total Premium	State HSA Contribution
EPO	Employee only	$20.92	$267.56	$288.48	-
	Employee + adult	$62.23	$549.72	$611.95	-
	Employee + child	$52.82	$357.07	$409.89	-
	Family	$115.57	$602.26	$717.83	-
PPO	Employee only	$53.34	$271.94	$325.28	-
	Employee + adult	$112.43	$575.01	$687.44	-
	Employee + child	$75.30	$384.80	$460.10	-
	Family	$131.25	$670.85	$802.10	-
HDHP	Employee only	$10.15	$180.97	$191.12	$27.69
	Employee + adult	$30.46	$375.07	$405.53	$55.38
	Employee + child	$25.89	$245.18	$271.07	$55.38
	Family	$56.35	$417.88	$474.23	$55.38

* University of Arizona has 24 pay period deductions

Figure 4: Active Medical Premiums per Pay Period (26 pay periods) for 01/01/2019 through 06/30/2019

Active rates effective 07/01/2019 through 12/31/2019 (first two quarters of FY 2020) based on a bi-weekly (26 pay periods per year) calendar:

Active Medical Premiums per Pay Period (26 pay periods)*					
Plan	Tier	Employee Premium	State Premium	Total Premium	State HSA Contribution
EPO	Employee only	$20.92	$268.90	$289.82	-
	Employee + adult	$62.23	$552.47	$614.70	-
	Employee + child	$52.82	$358.86	$411.68	-
	Family	$115.57	$605.27	$720.84	-
PPO	Employee only	$53.34	$273.30	$326.64	-
	Employee + adult	$112.43	$577.89	$690.32	-
	Employee + child	$75.30	$386.73	$462.03	-
	Family	$131.25	$674.20	$805.45	-
HDHP	Employee only	$10.15	$181.87	$192.02	$27.69
	Employee + adult	$30.46	$376.95	$407.41	$55.38
	Employee + child	$25.89	$246.41	$272.30	$55.38
	Family	$56.35	$419.97	$476.32	$55.38

* University of Arizona has 24 pay period deductions

Figure 5: Active Medical Premiums per Pay Period (26 pay periods) for 07/01/2019 through 12/31/2019

The PY 2019 Retiree premium rates increased 3% when compared to PY 2018 rates:

Monthly retiree rates effective 01/01/2019 through 12/31/2019:

Monthly Retiree Medical Premiums				
	Without Medicare		With Medicare	
Plan	Tier	Premium	Tier	Premium
EPO	Retiree only	$671.87	Retiree only	$500.79
	Retiree +1	$1,571.47	Retiree +1 (Both Medicare)	$994.77
			Retiree +1 (One Medicare)	$1,160.19
	Family	$2,117.58	Family (Two Medicare)	$1,321.08
PPO	Retiree only	$934.73	Retiree only	$893.94
	Retiree +1	$2,276.20	Retiree +1 (Both Medicare)	$1,785.61
			Retiree +1 (One Medicare)	$1,971.42
	Family	$2,489.20	Family (Two Medicare)	$2,243.34

Figure 6: Monthly Retiree Medical Premiums

Medical Premium vs. Plan Cost

The PY 2019 contribution strategy for the self-insured medical plan resulted in employees paying 12% of the average monthly premium while the state paid the remaining 88%. This ratio remains mostly unchanged from PY 2018 despite one-time increases to the employer portion of premiums. The overall premium revenues collected in PY 2019 were not sufficient to cover expenses in PY 2019, and the fund was not structurally balanced. The fund had a sufficient carry-over balance from prior years to cover all expenses in the fund in PY 2019.

The one-time employer premium FY 2019 infusion of 5.4%, effective in July 2018, generated an additional $15.6M of revenue to the HITF in PY 2018 (close to $31.2M annually by the end of June 2019). This one-time infusion was rolled back and replaced by a new one-time FY 2020 infusion of 5.9%. This infusion is projected to bring in a total of $34.4M in FY 2020, of which $17.2M took place in PY 2019. The only plan changes for PY 2019 were new deductibles put in place for the EPO plan.

The figure below shows how the average monthly premium compared to the average monthly plan cost for Active employees and Retirees and their dependents (Active and Retiree members). Pursuant to A.R.S. §38.651.01 (B), Retiree and Active medical expenses shall be grouped together to "obtain health and accident coverage at favorable rates." This requirement results in lower Retiree premiums and higher Active premiums than what their experiences would otherwise dictate.

Expenses for Self-Insured Medical Plans

The figures below show the distribution of PY 2019 incurred claims and other expenses (paid in January 2019 through March of 2020), and the average annual cost to insure each type of subscriber/member.

2019 Incurred and Paid Self-funded Medical Expenses by Active, Retiree, and Plan						
Expenses	**Overall**	**Active**	**Retiree**	**EPO**	**PPO**	**HDHP**
Medical Claims	$591,798,229	$548,203,990	$43,594,239	$474,149,433	$98,078,038	$19,570,758
Drug Claims	$199,805,802	$157,900,514	$41,905,288	$165,264,847	$29,939,129	$4,601,826
Medicare Part D Subsidy	($6,220,577)	$0	($6,220,577)	($5,266,505)	($954,072)	$0
Rebates & Recoveries	($16,923,881)	($13,374,434)	($3,549,447)	($13,998,205)	($2,535,894)	($389,782)
Administration Fees	$27,531,586	$24,666,015	$2,865,571	$22,364,672	$3,356,887	$1,810,026
Operating Expenses & Adj.	$5,101,906	$4,567,266	$534,640	$4,172,657	$626,307	$302,942
Total Expenses	$801,093,064	$721,963,351	$79,129,713	$646,686,899	$128,510,396	$25,895,770
IBNR Liability	$13,505,151	$12,510,307	$994,844	$10,820,343	$2,238,193	$446,615
Total	$814,598,215	$734,473,658	$80,124,557	$657,507,242	$130,748,589	$26,342,385
Enrollment in self-funded plans						
Subscribers	61,807	55,330	6,477	50,550	7,587	3,670
Members	136,547	127,990	8,557	110,462	17,830	8,255
Annual cost						
Per subscriber	$13,180	$13,274	$12,371	$13,007	$17,232	$7,178
Per member	$5,966	$5,739	$9,364	$5,952	$7,333	$3,191

Figure 7: 2019 Incurred and Paid Self-funded Medical Expenses by Active, Retire, and Plan

2019 Incurred and Paid Self-funded Medical Expenses by Plan for Active & Retiree						
		Active	**Active**	**Active**	**Retiree**	**Retiree**
Expenses (in dollars)	**Overall**	**EPO**	**PPO**	**HDHP**	**EPO**	**PPO**
Medical Claims	$591,798,229	$431,782,527	$96,850,706	$19,570,758	$42,366,906	$1,227,333
Drug Claims	$199,805,802	$124,971,903	$28,326,785	$4,601,826	$40,292,944	$1,612,344
Medicare Part D Subsidy	($6,220,577)	$0	$0	$0	($5,266,505)	($954,072)
Rebates & Recoveries	($16,923,881)	($10,585,326)	($2,399,325)	($389,782)	($3,412,879)	($136,568)
Administration Fees	$27,531,586	$19,583,274	$3,272,715	$1,810,026	$2,781,399	$84,172
Operating Expenses & Adj.	$5,101,906	$3,653,722	$610,602	$302,942	$518,936	$15,704
Total Expenses	$801,093,064	$569,406,099	$126,661,483	$25,895,770	$77,280,800	$1,848,913
IBNR Liability	$13,505,151	$9,853,507	$2,210,185	$446,615	$966,835	$28,008
Total	$814,598,215	$579,259,606	$128,871,667	$26,342,385	$78,247,636	$1,876,921
Enrollment in self-funded plans						
Subscribers	61,807	44,263	7,397	3,670	6,287	190
Members	136,547	102,155	17,580	8,255	8,307	250
Annual cost						
Per subscriber	$13,180	$13,087	$17,422	$7,178	$12,447	$9,866
Per member	$5,966	$5,670	$7,331	$3,191	$9,419	$7,508

Figure 8: 2019 Incurred and Paid Self-funded Medical Expenses by Plan for Active, Retiree

Medical Expenses Associated with Medical Diagnoses

The tables below show the trend in cost by diagnosis for Actives and Retirees. For Actives, the first ten categories make up approximately 72.6% ($429.4M) of the total PY 2019 medical spend or 78.3% of the PY 2019 active members total medical spend. The total spend for the top ten medical categories for Actives has decreased by 4.2% (negative $19M) as compared to PY 2018, from ($448.4M to $429.4M). The neoplasms (cancers/tumors) diagnosis group has experienced the largest percentage growth as well as spend growth for the Active population in PY 2019 over PY 2018 with an 8.5% increase and a total growth in spending of $3.8M ($45.3M to $49.1M). The circulatory system diagnosis group has experienced the largest percentage drop as well as spend drop from PY 2018 to PY 2019 of (13.5%), or negative ($6.1M), a decrease from $45.1M to $39M.

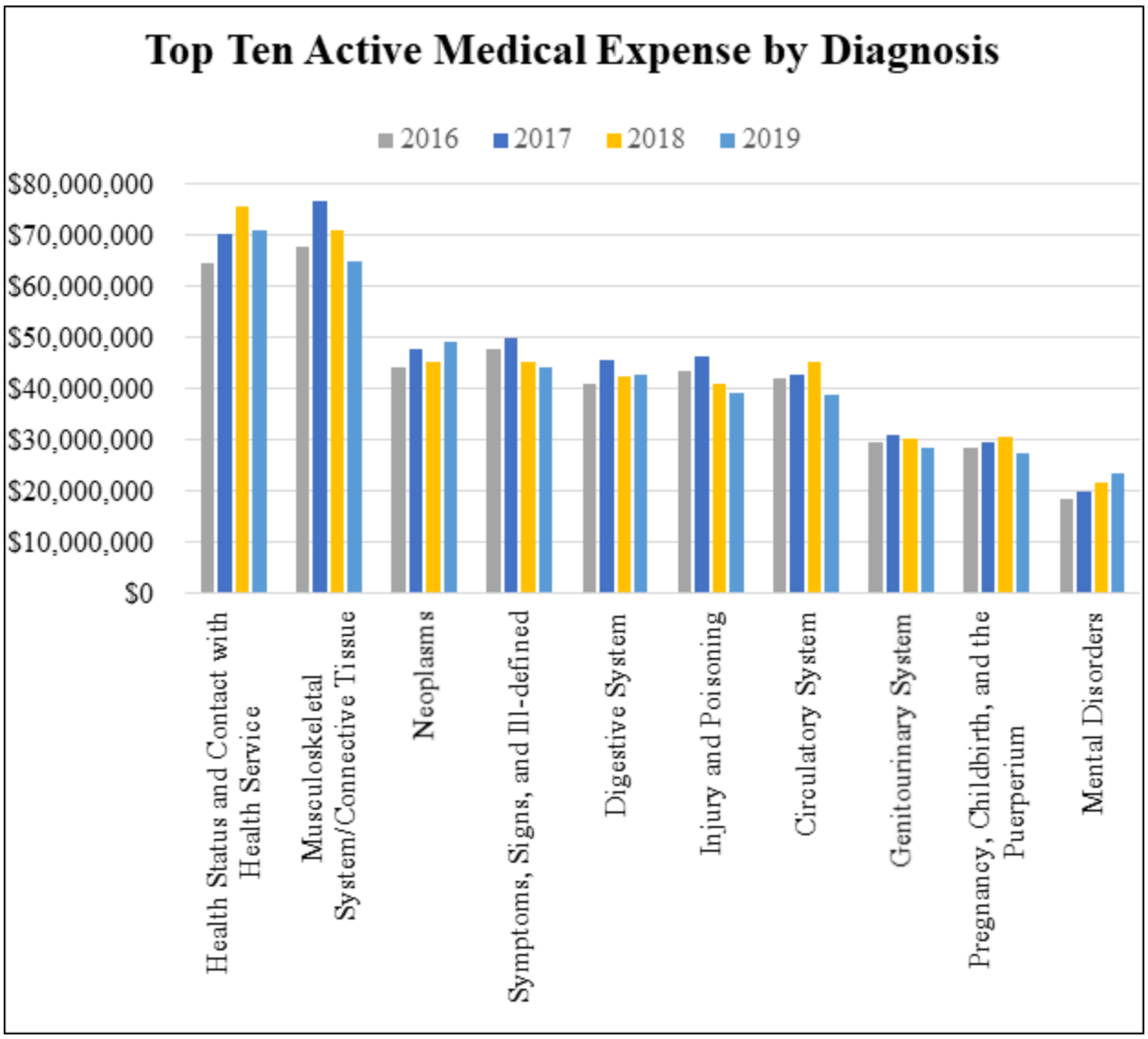


Figure 9: Top Ten Active Medical Expense by Diagnosis

For Retirees, spending on the top ten categories has decreased in PY 2019 over PY 2018 by 8.3% ($3.3M). The top ten categories make up approximately 81.6%, or $35.7M, of the total PY 2019 Retiree medical spend, or 6% of the total medical spend. The Musculoskeletal System/Connective Tissue treatment group continues as the largest spend category for the Retiree population. The highest percentage growth for the Retiree population was also observed in the Health Status and Contact with Health Service group with a 12.6% increase in expenditures PY 2019 over PY 2018. The largest spend increase of $540K (from $6.4M to $6.6M) occurred in the Musculoskeletal System/Connective Tissue group. The largest percentage decrease of 46.8% was observed in the Circulatory diagnosis group. In addition, this group also had the largest spend decrease of $2.7M in PY 2019 as compared to PY 2018. The overall spend decrease was caused, in most part, by the drop in retiree enrollment in PY 2019 over PY 2018.

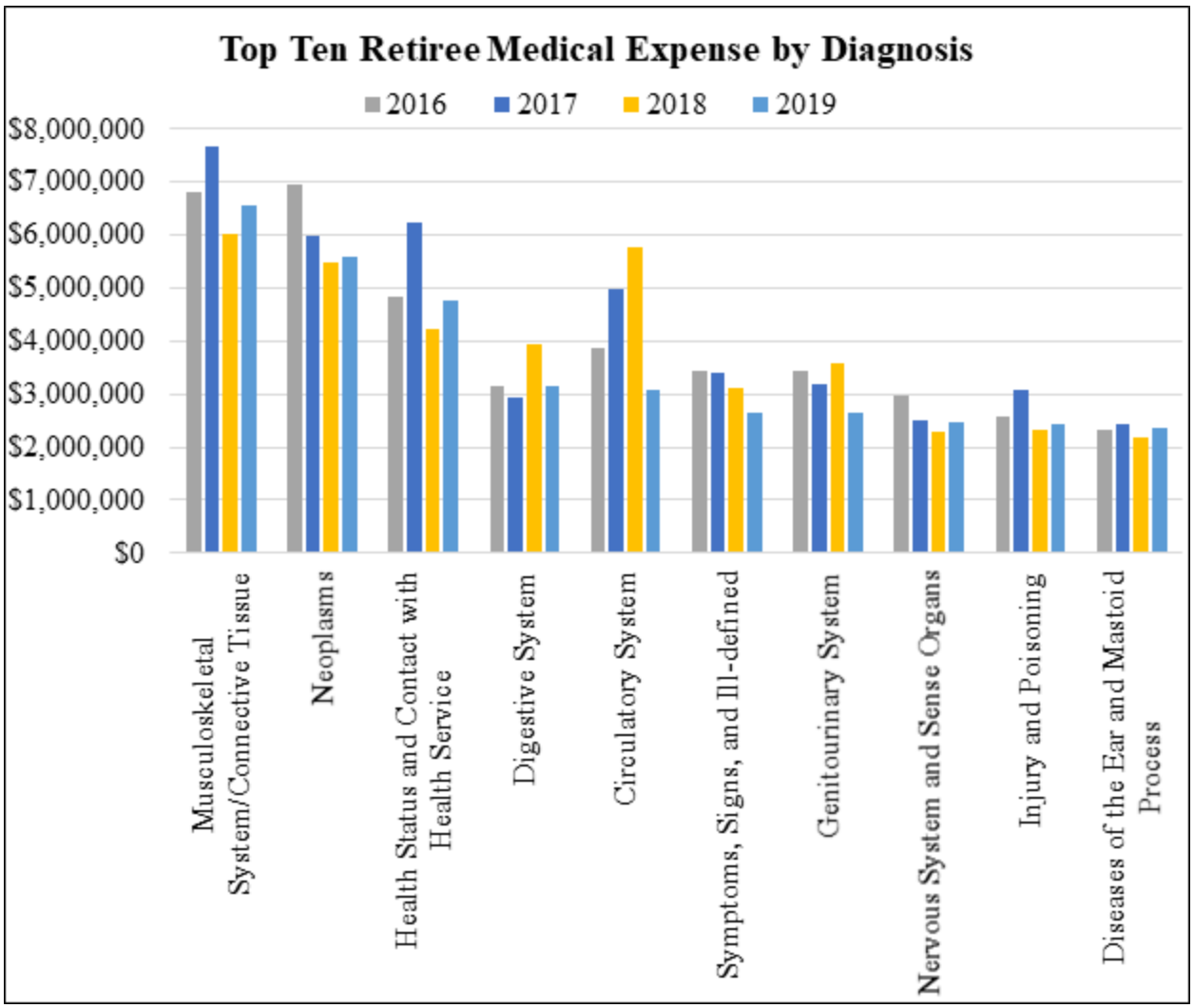


Figure 10: Top Ten Retiree Medical Expense by Diagnosis

Inpatient Hospital Care

Inpatient hospital care represents a significant portion of total medical expenses. Inpatient hospital care includes the cost of hospitalizations, skilled nursing facilities, and hospice. The tables below show the hospital admissions per 1,000 members and the average length of stay. The Retiree population was, on average, admitted more times per member and for longer hospital stays than the Active population. When comparing plans, PPO members are admitted more often than EPO members, who are admitted more often than HDHP members. This is in line with the average costs of these members in each plan. The length of stay has historically been similar between the EPO and PPO, while the Active employees in the HDHP tend to have a shorter length of stay. However, there has been a significant pick up in the length of stay for the HDHP population in PY 2018 that may be partially explained by more individuals signing up for the HDHP plan than previously.

The number of hospital admissions for the Retiree population has increased slightly. This could indicate a declining health trend in the older population. Alternatively, it could also point to improved access to healthcare. The number of hospital admissions for Actives has decreased to the lowest level in the last four years, a favorable development.

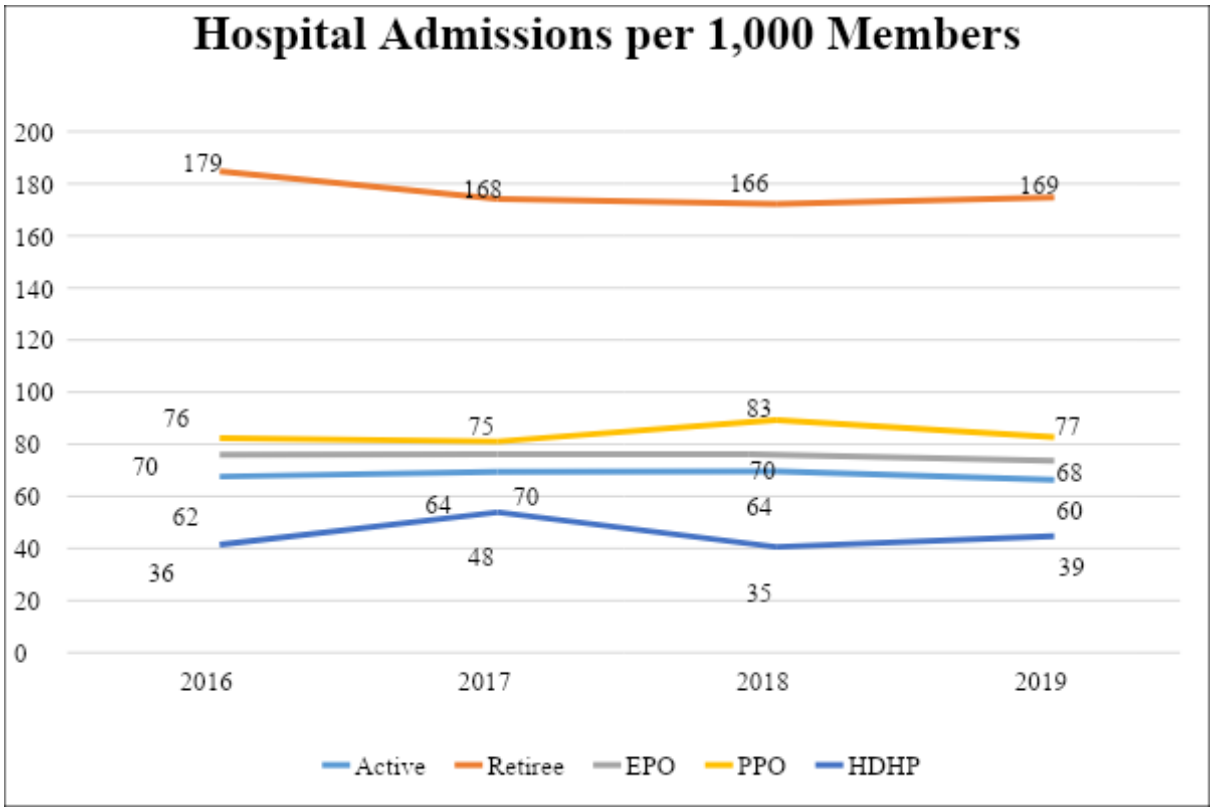


Figure 11: Hospital Admissions per 1,000 Members

The average inpatient length of stay for the Active population has decreased slightly for PY 2019 over PY 2018. The Retiree population has experienced a jump in the average inpatient length of stay from 7.3 to 7.7 for PY 2019 over PY 2018. The Retiree population tends to have a significantly higher average inpatient length of stay than the Active population as older members tend to be diagnosed with more serious conditions that require longer treatment and, thus, longer hospital stays.

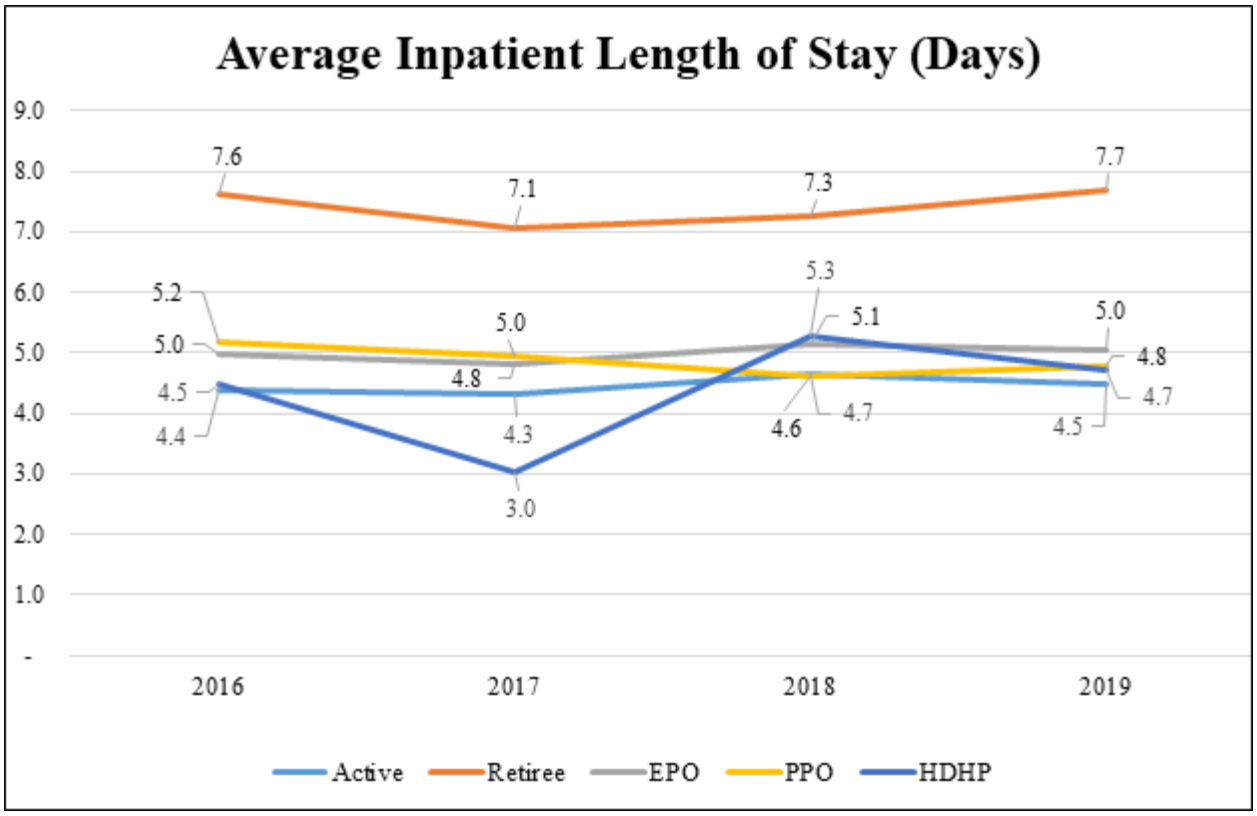
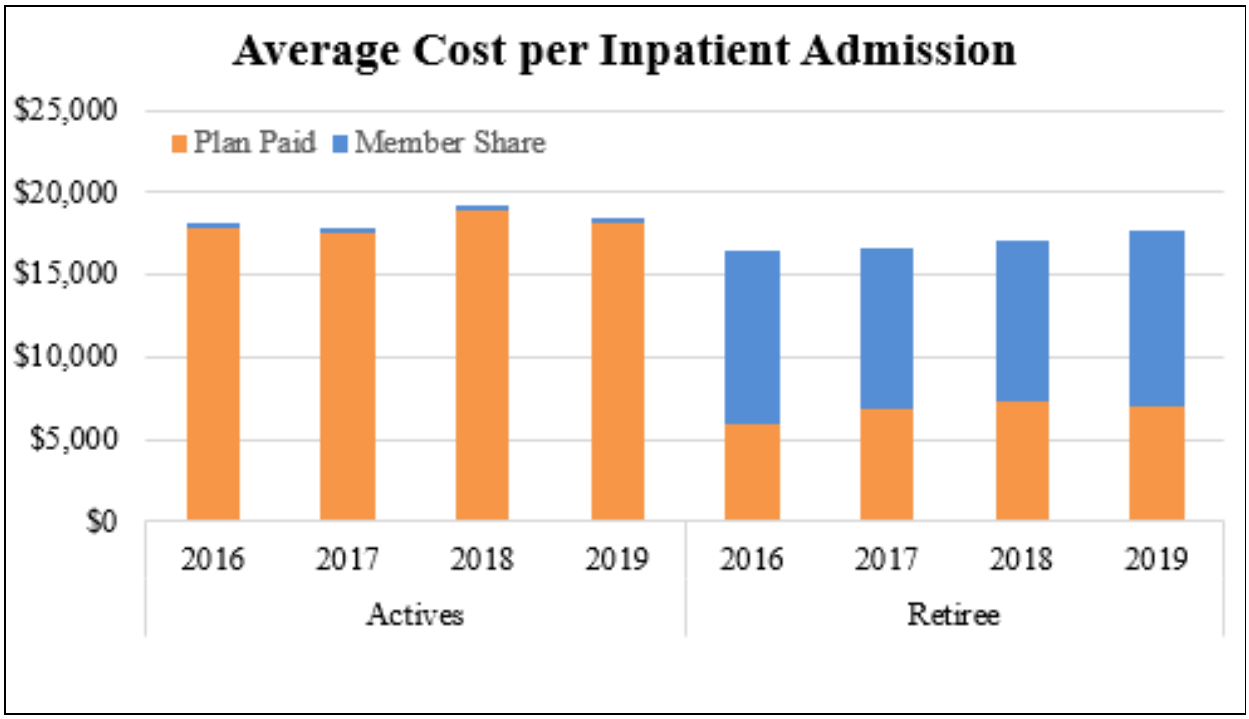


Figure 12: Average Inpatient Length of Stay

There is greater inpatient admission cost-sharing with the Retirees because approximately two-thirds of Retirees have Medicare paying as primary for their claims. Overall, the Plan paid approximately 97.7% ($140.1M of $143.3M total) of Active inpatient costs and 39.9% ($10.2M of $25.6M total) of Retiree inpatient costs during PY 2019. The average inpatient cost-sharing has averaged 98% over the last four years. For Retirees, the average cost share over the last four years is 40%, ranging between 36.3% in PY 2016 and 42.4% in PY 2018. The chart also indicates that the Retirees average cost per admission runs slightly less than for Actives. The cost per admission includes the cost of skilled nursing facilities, which Retirees use more frequently than Actives. This drives the cost per admission down since skilled nursing facility care is less expensive than traditional hospital stays. Often, retirees require additional medical care following hospital admissions, resulting in more frequent visits, and therefore they are overall higher on a per member per month basis.



** Includes copay, coinsurance, Medicare, and other insurance*

Figure 13: Average Cost per Inpatient Admission – Actives and Retirees

The average Per Member Per Month (PMPM) per hospital admission costs are displayed below. The PMPM cost is simply calculated by taking the total annual cost of all hospital admissions divided by the average medical membership and then divided by twelve (months). The Plan is seeing a drop in PY 2019 over PY 2018 for both populations. There can be many explanations for this drop. For one, the overall health of the population may be getting better, resulting in fewer hospital bed days or a lower cost of treatment while in the hospital. Further, a decrease in the costs of hospital admissions can be due to more procedures being performed in an outpatient setting instead of inpatient.

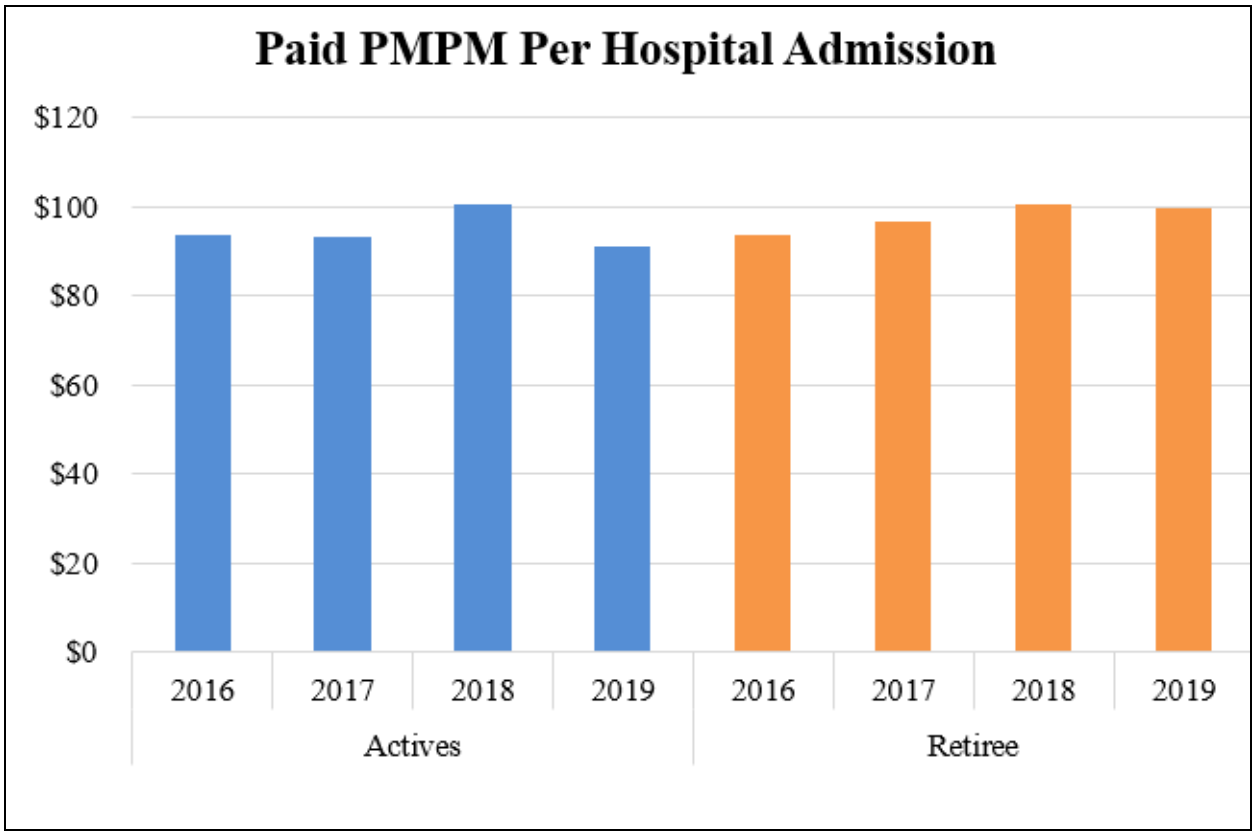
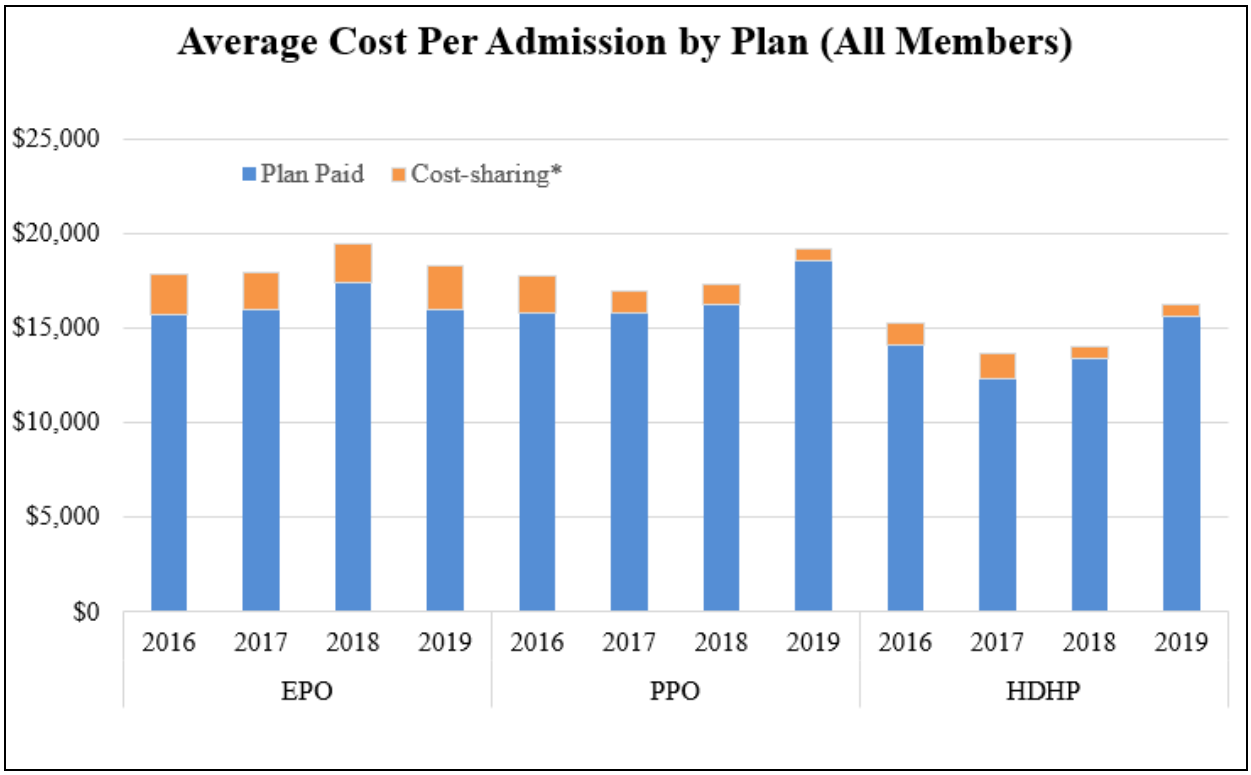


Figure 14: Plan Paid PMPM per Hospital Admission – Active and Retiree

Referencing the total cost-share per admission by plan chart, below, greater average costs per admission costs were realized in the EPO and PPO plan than in the HDHP plan. This is partly due to Retirees not being eligible for the HDHP. During PY 2019, the Plan paid approximately 87.2% ($119.6M of $137.2M total) of EPO, 96.6% ($25.5 M of $26.3 M total) of PPO, and 96.2% ($5M of $5.2M total) of HDHP inpatient costs during PY 2019.



** Includes copay, coinsurance, Medicare, and other insurance*

Figure 15: Average Cost per Admission – EPO, PPO, and HDHP

Place of Service

The figures below show the total cost by place of service for Active and Retirees over the past four years. The Inpatient setting continues to be the highest cost driver for the Active population. In contrast, the Outpatient setting is the top place of service for the Retiree population with Inpatient setting close behind. Pharmacy costs, if they were to be included as one of the categories, would be the top expenditure category of service for the Retiree population and in second place for the Active population. In fact, for the Retiree population, the pharmacy costs constitute 48.5% of total medical costs, while for the active population, pharmacy costs make up a 22.1% share.

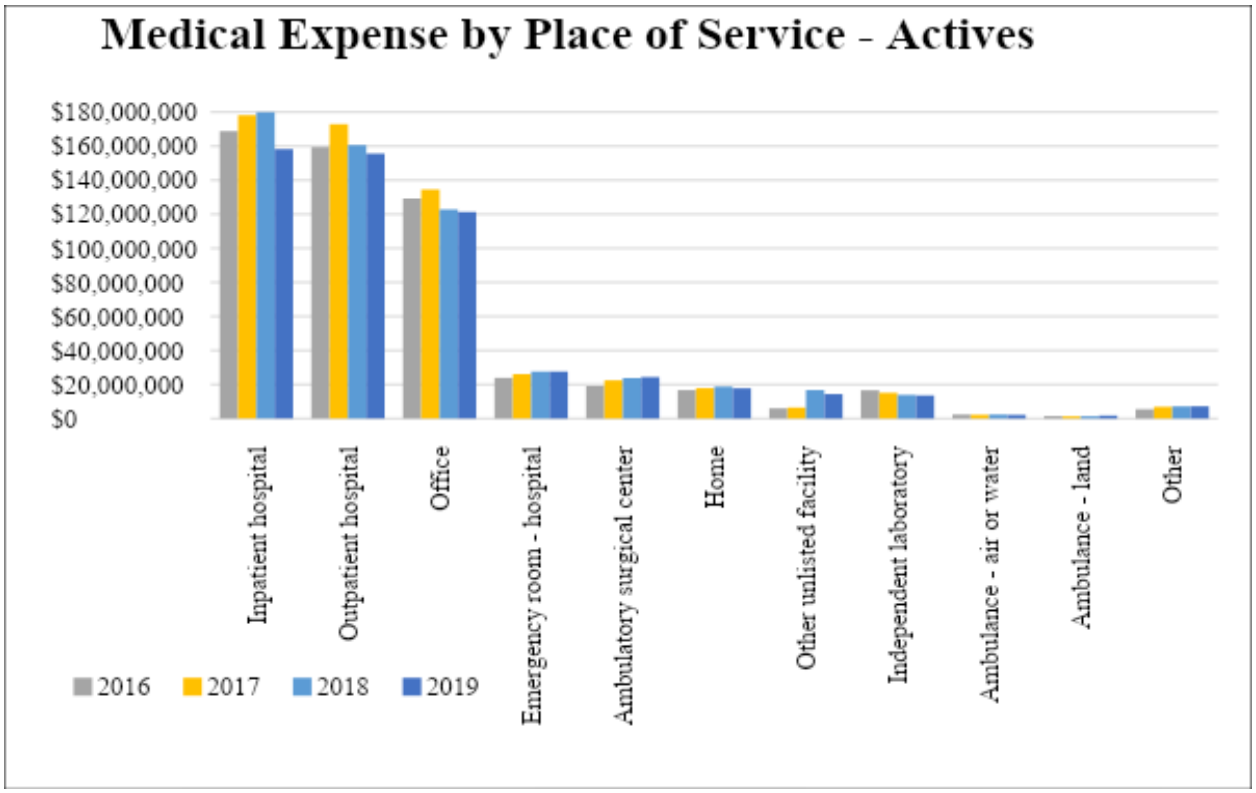


Figure 16: Medical Expense by Place of Service – Actives

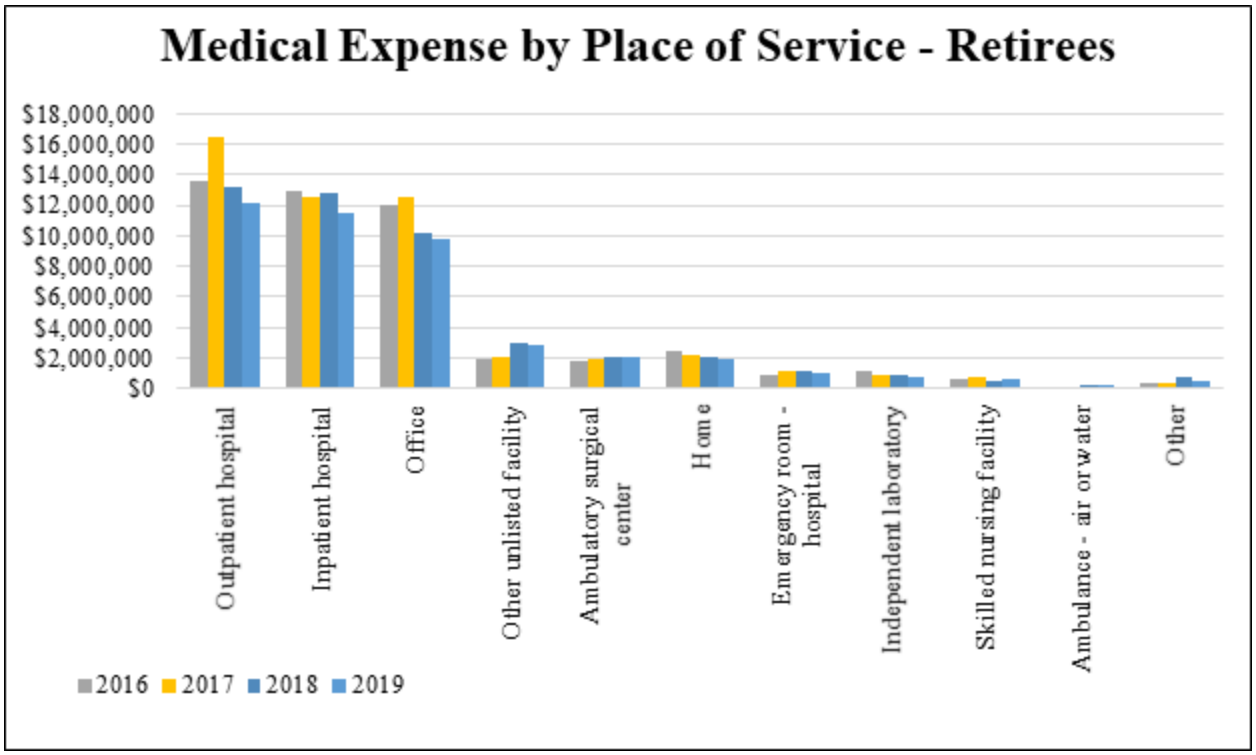


Figure 17: Medical Expense by Place of Service – Retirees

Emergency Services

During PY 2019, there were approximately 189 emergency room visits per 1,000 members of the self-funded plan.

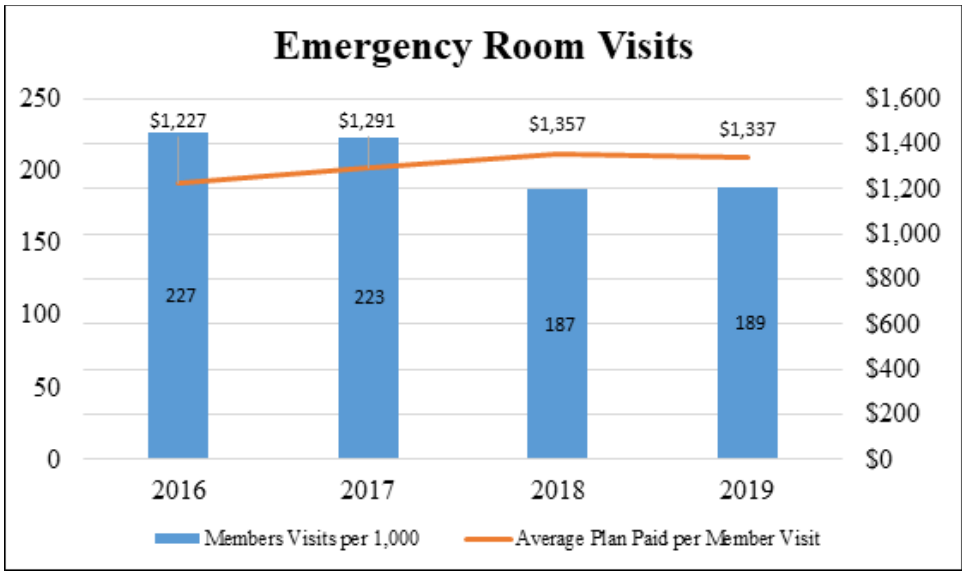


Figure 18: Emergency Room Visits

This represents a minor increase over the PY 2018 number of member visits per 1,000, which was 187. The average plan cost per visit was $1,337 (inclusive of both facility and professional costs), lower than in PY 2018 but still higher than in PY 2016 and PY 2017. To drive down the non-emergent utilization of emergency rooms, the Benefit Services Division has implemented several initiatives in PY 2018 and PY 2019 that have proven successful. Specifically – members were awarded Health Impact Plan (HIP) points for downloading Doctor on Demand, a telemedicine application, and had the chance to participate in a prize drawing for a Fitbit Flex. A rigorous communication campaign was launched by BSD in conjunction with medical vendors in PY 2019 to educate employees regarding health decisions and the appropriate use of healthcare services, as well as to encourage the use of telemedicine through Doctor on Demand or through telemedicine offerings directly through the medical vendors. In addition, the increased annual deductible for the EPO plan has further driven the decrease in utilization of emergency room services, steering members to utilize alternative and less costly services such as convenience care/walk-in clinics, urgent care, and primary care physician offices.

Urgent Care Visits

During PY 2019, there were approximately 184 urgent care visits per 1,000 members of the self-funded plan. This is higher than in PY 2018 but still significantly lower than in PY 2016 and PY 2017.

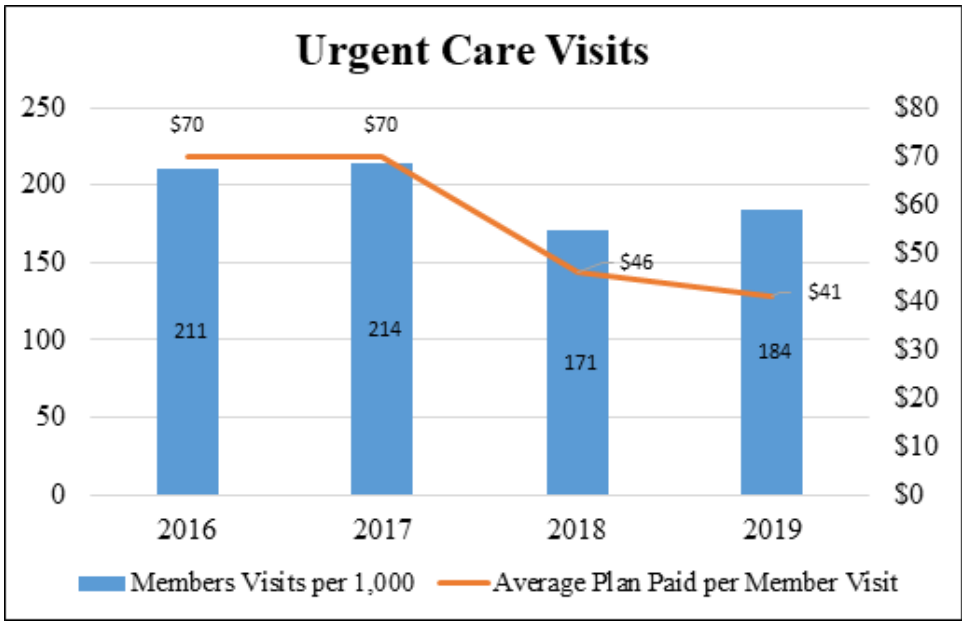


Figure 19: Urgent Care Visits

The average plan paid cost of urgent care visits dropped again in PY 2019 from $46 to $41; a notable drop over PY 2016 and PY 2017. The copays on urgent care visits increased from $40 to $75 per visit in PY 2018 and had a major downward effect on member utilization of services in both PY 2018 and PY 2019, as well as on the average cost of urgent care visits. The higher copays resulted in higher employee cost share while decreasing the costs to the plan.

Physician Visits

During PY 2019, there were approximately 3,664 physician visits per 1,000 members of the self-funded plan, or each member of the plan visited a physician's office close to four times a year on average.

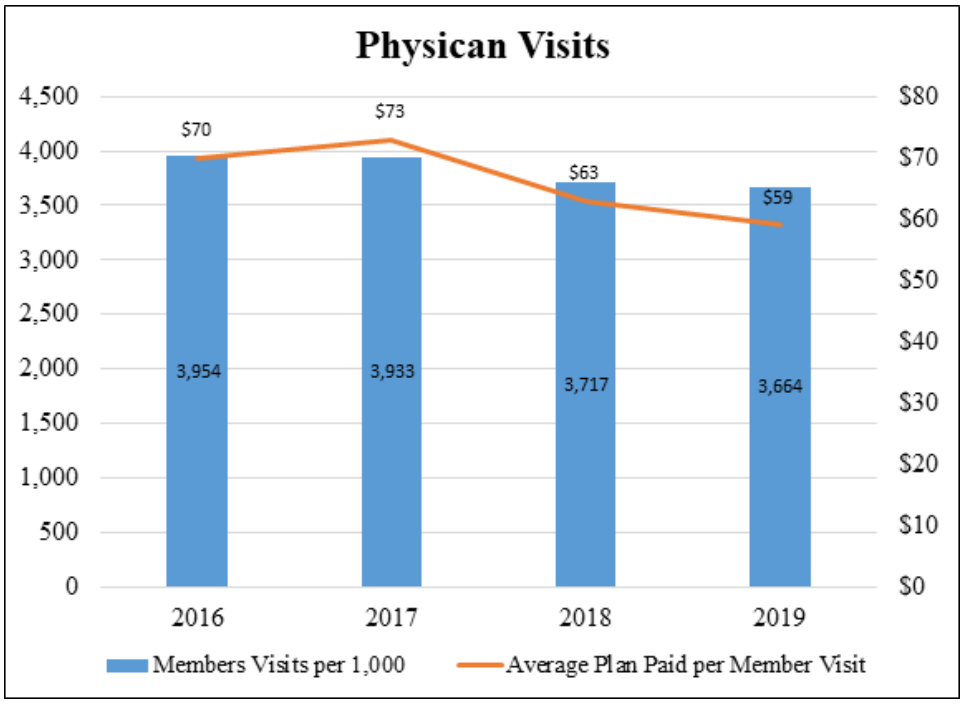


Figure 20: Physician Visits

Utilization in PY 2019 was lower than in the prior three years, where it ranged between 3,717 in PY 2018 and 3,954 in PY 2016. ADOA is having difficulties understanding this new trend since preventative care visits were covered at no cost to the member in PY 2019. The plan is closely monitoring the situation. The average plan cost per office visit in PY 2019 was $59, the lowest of the past four years, with PY 2017 being the highest at $73.

Annual Prescription Use

The table below shows the average number of prescriptions filled by active and retiree members and by the total of all members, including those that did not utilize the pharmacy benefit at all during the year. The retirees fill prescriptions an average three times the amount of prescriptions filled by the actives. The chart shows a downward trend for both the active and the retiree. There was a respectable decrease in the total utilization of drugs in PY 2018 over PY 2017. This can be attributed to increased copays that went into effect in PY 2018. However, the average number of prescriptions between PY 2019 and PY 2018 has not experienced any significant changes.

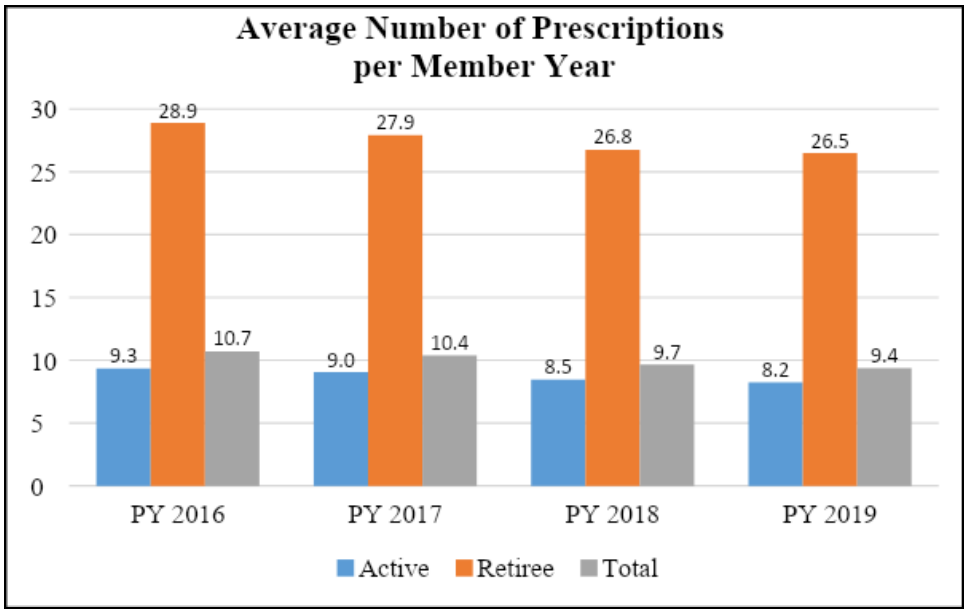


Figure 21: Average Number of Prescriptions Per Member Per Year

The cost of an average prescription refill is higher for the retiree group than for actives. The cost of each refill has been increasing rapidly for both the active and retiree populations over the last four years. ADOA research has found that there has been no significant increase in research and development activities over the last several years. The main takeaway is that increases in prices of brand-name drugs were largely driven by year-over-year price increases of drugs that were already on the market. The drug price increases were the result of lack of competition (many name-brand medications are protected against generic competitors due to patents), mergers, and acquisitions in the pharmaceuticals industry, and only partially due to high costs of newly developed specialty drugs. According to *Health Affairs* magazine, a study published in January 2019, older name-brand drug prices increased close to 9% annually, far exceeding inflation rates. Interestingly, even prices of generic drugs have risen between 4% - 7% in the analysis.

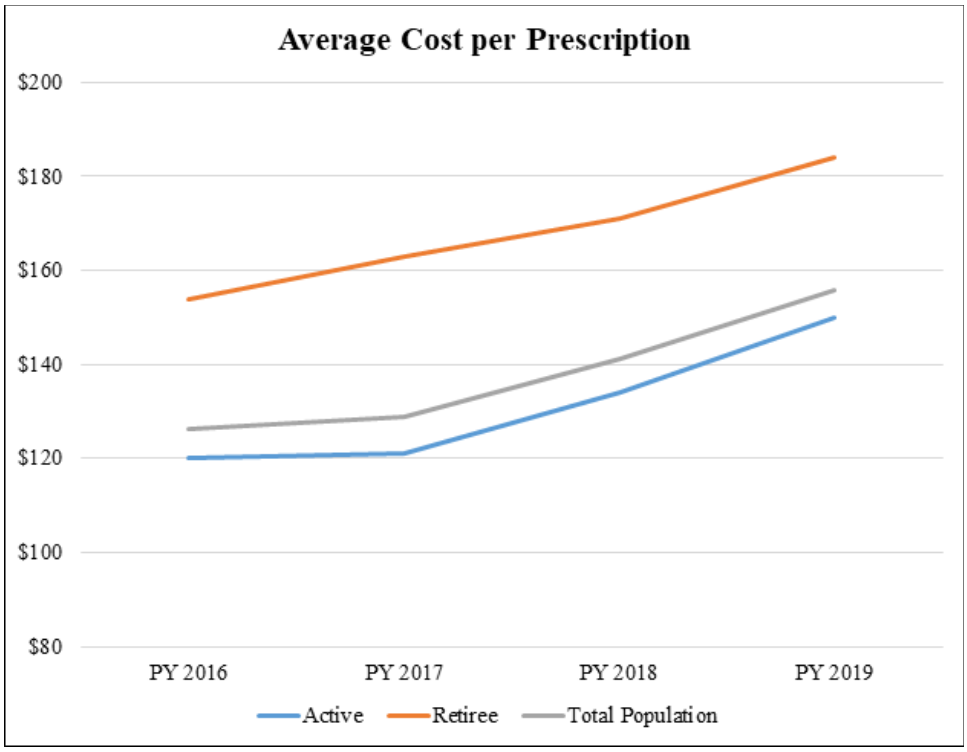


Figure 22: Average Cost per Prescription

While the average number of prescriptions per member per year has been decreasing over the last few years, the annual cost per utilizing member is steadily increasing. This indicates an increasing overall cost in the pharmacy benefit.

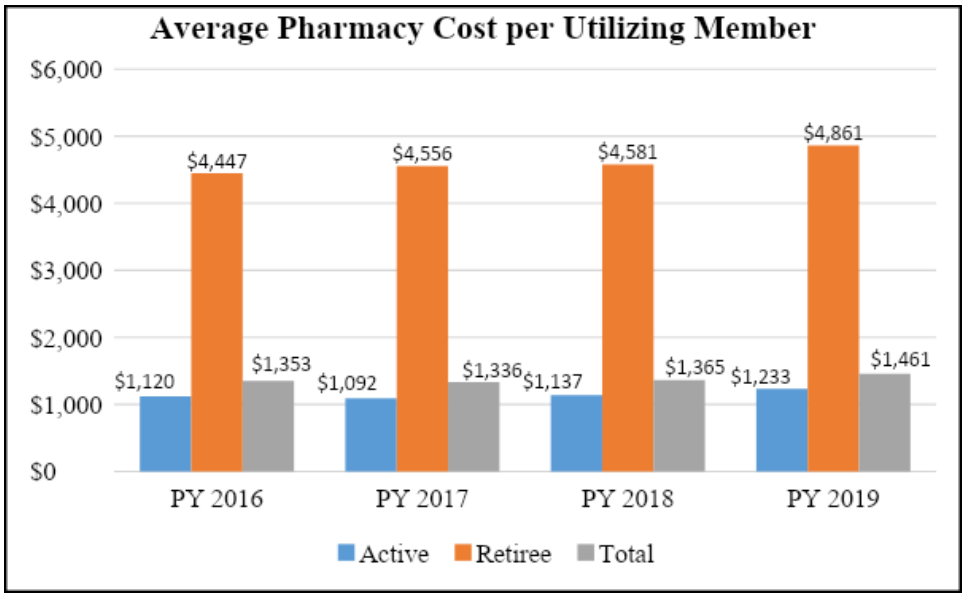


Figure 23: Average Pharmacy Cost per Utilizer

Generic and Brand-name Prescription Utilization

The table below shows a positive trend overall in the utilization of lower-cost drugs. However, in PY 2018, there has been an uptick in the utilization of tier 2 and tier 3 drugs, while in PY 2019, that trend has reversed itself. Generic (Tier 1) drugs tend to have the lowest overall cost to the plan, preferred name-brand drugs (Tier 2) have a higher cost to the plan, and non-preferred brand name drugs (Tier 3) tend to have the highest cost to the plan.

MedImpact is the drug provider for all of our medical plans. MedImpact works with a committee of doctors and pharmacists to compile the Plan's formulary that is a list of medications itemized by the three-drug tiers. The "Benefit Options Formulary" is the name of the Plan's formulary, and its goal is to provide the most clinically effective drugs at the lowest cost.

A generic drug is a drug that is comparable to a brand name/reference listed drug product in dosage form, strength, route of administration, quality and performance characteristics, and intended use. Generic drugs are usually referred to by its chemical name and are made available on the market when the patent protection on the brand name drug expires. The major difference between a generic drug and brand name drug is the price. It is important to note that generic drugs are just as safe and effective as name brand drugs.

The non-preferred brand name drugs are name-brand drugs that cost significantly more than preferred name-brand drugs and therefore require higher co-pays. Further information regarding the full formulary, please visit benefitoptions.az.gov/employees/pharmacy.

Although not readily apparent from the chart, the overall number of written prescriptions has been steadily decreasing since PY 2016. In fact, the number of prescriptions/scripts decreased 10.8% from PY 2016 to PY 2019.

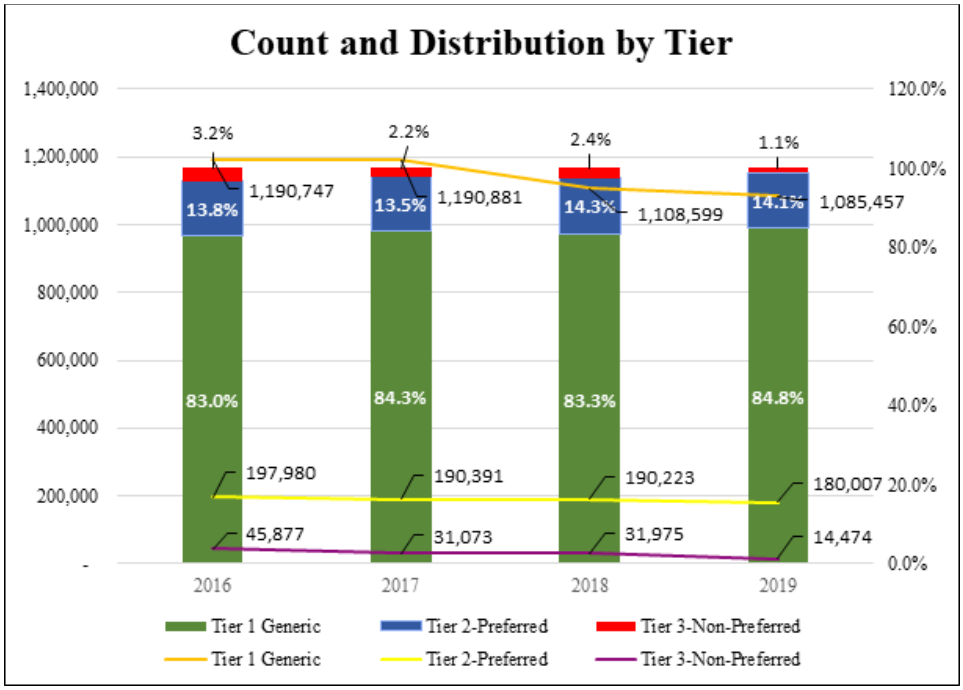


Figure 24: Pharmacy Count and Distribution by Tier

Prescription Spend by Therapeutic Class

The following graph shows spend by therapeutic class by year. The expenditures on the top ten therapeutic classes have steadily been increasing over the last four years in line with total pharmacy spend. The top ten therapeutic classes comprise 66.8% ($133.2M out of $199.4M) of total pharmacy spent in PY 2019. In PY 2019, the plan has seen the assorted drug class making it into the top ten therapeutic classes by spend, while displacing the anticonvulsant therapeutic class. The assorted drug class encompasses drugs that do not fall easily into any of the major categories of drugs. In nine out of the top ten classes, expenses have increased PY 2019 over PY 2018. Diabetes and inflammatory disease continue to be the highest therapeutic class cost, drivers.

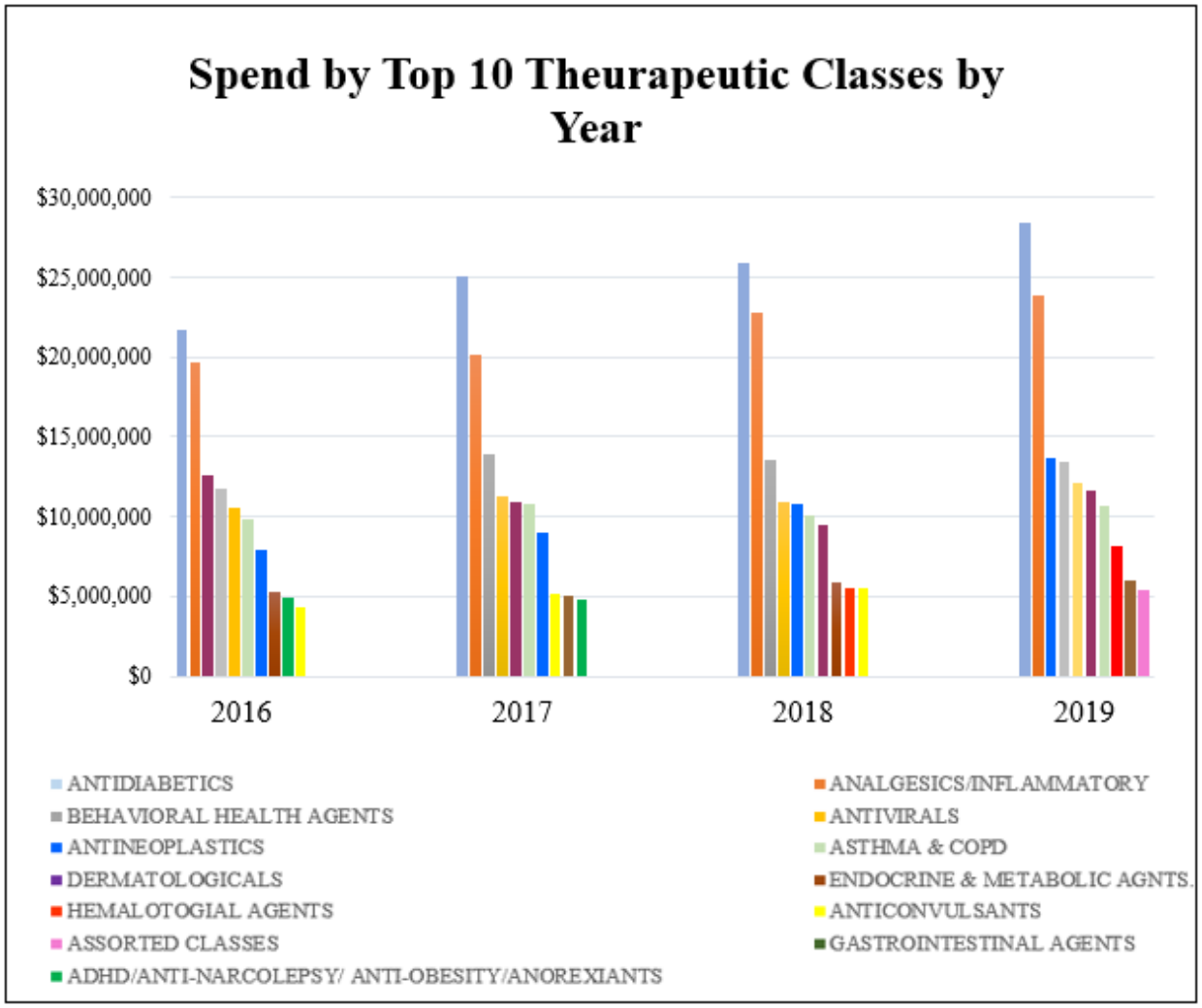


Figure 25: Prescription Spend by Top 10 Therapeutic Class by Year

Prescription Spend by Type of Drug

The graph below shows the spend for the top ten drugs by year. In all of the top ten drugs, expenses have increased. The top ten drugs make up approximately 20.6% ($41.1M) of the total PY 2019 drug spent, which is slightly up from the prior year of 19.4%. The top two drugs in PY 2019 are the Humira Pen, a drug to treat inflammation, and Revlimid, which is prescribed to treat certain cancers. Eliquis, a drug used to treat and prevent blood clots, Hemlimbra, a hemophilia treatment, and Stelara, an immunosuppressive drug used to treat psoriatic arthritis and plaque psoriasis, made it into top ten prescriptions in PY 2019. Lantus Solostar, a type of insulin used to treat diabetes, Victoza, an anti-diabetic medication, and Lyrica, a drug used to treat muscle and nerve pain, fibromyalgia, and seizures, are no longer on the top ten list.

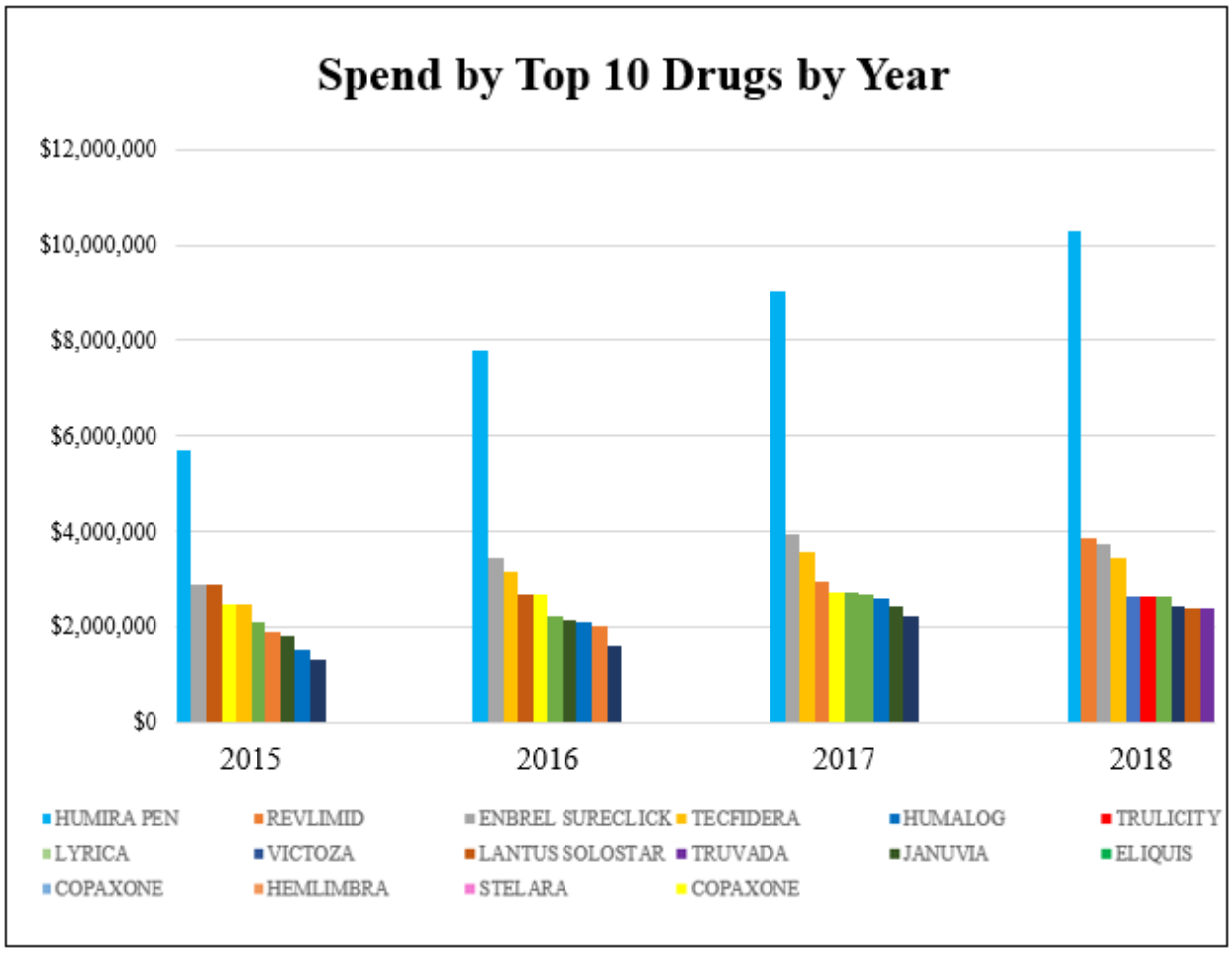


Figure 26: Spend by Top 10 Drugs by Year

Dental Plan Enrollment

In PY 2019, Benefit Services Division offered two different types of dental plans: a fully insured Dental Health Maintenance Organization (DHMO) plan administered by Cigna Dental and a self-insured Dental Preferred Provider Organization (DPPO) plan administered by Delta Dental.

DHMO Plan
Within the DHMO plan, services must be obtained from a participating dental provider (PDP). There are no annual deductibles or out of pocket maximums. The plan coverage maximums include a $200 maximum reimbursement for non-PDP emergency services, $50 for emergency services less member cost-share for the service.

DPPO Plan
Within the DPPO plan, services may be obtained from any dentist, and deductibles and out-of-pocket maximums apply. Benefits may be based on reasonable and customary charges. The plan coverage maximums include a $2,000 maximum per person per year and a $1,500 per person lifetime maximum for orthodontia. Delta Dental administers this plan. The figure below shows how enrollment was distributed by plan and network between Active, Retired, University, and COBRA members. The subscriber references the employee and the member references the employee plus dependents.

In PY 2019, the total dental enrollment increased slightly by about 1% or 1,468 members. Over two-thirds of the increase took place in the fully insured dental plan administered by Cigna Dental.

Average Monthly Dental Enrollment by Plan

		2019		2018	
Network	**Plan Type**	**Subscribers**	**Members**	**Subscribers**	**Members**
Active	DPPO	19,570	46,615	20,415	48,596
Retiree	DPPO	15,377	24,427	14,676	23,256
University	DPPO	16,734	36,107	16,535	34,916
COBRA	DPPO	196	341	191	297
Total Delta Dental		**51,877**	**107,491**	**51,817**	**107,065**
Active	DHMO	11,765	27,202	11,403	27,192
Retiree	DHMO	2,398	3,664	2,348	3,594
University	DHMO	6,439	13,539	5,967	12,586
COBRA	DHMO	82	136	74	127
Total Cigna Dental		**20,684**	**44,541**	**19,792**	**43,500**
Total		**72,561**	**152,032**	**71,609**	**150,564**

Figure 27: Average Monthly Dental Enrollment by Plan Dental Premiums

The below tables show the dental premiums by plan and coverage tier per pay period for Active employees based on an annual 26 pay period payroll cycle and monthly rates for Retirees.

Active Dental Premiums per Pay Period (26 pay periods)*				
Plan	**Tier**	**Employee Premium**	**State Premium**	**Total Premium**
DPPO	Employee only	$14.30	$2.29	$16.59
	Employee + adult	$30.33	$4.58	$34.91
	Employee + child	$23.34	$4.58	$27.92
	Family	$48.26	$6.32	$54.58
DHMO	Employee only	$1.64	$2.29	$3.93
	Employee + adult	$3.29	$4.58	$7.87
	Employee + child	$3.08	$4.58	$7.66
	Family	$5.46	$6.32	$11.78

Figure 28: Active Dental Premiums per Pay Period (26 pay periods)

Retiree Monthly Dental Premiums		
Plan	**Tier**	**Premium**
DPPO (Delta Dental)	Employee only	$35.94
	Employee + adult	$75.63
	Employee + child	$60.48
	Family	$118.26
DHMO (Cigna Dental)	Employee only	$8.52
	Employee + adult	$17.04
	Employee + child	$16.59
	Family	$25.54

Figure 29: Retiree Monthly Dental Premiums

Dental Premium vs. Plan Cost

Cigna Dental replaced Total Dental Administrators (TDA) as the DHMO plan in PY 2019. Cigna Dental's premiums in PY 2019 were lower than TDA's in PY 2018 while offering a broader range of services at comparable or lower costs. The plan also offers no deductibles or dollar limits. However, services must be obtained from an in-network provider, and out-of-network services are only covered in emergencies. Further, this plan is not available in all states and territories. The Active members on the DPPO plan are paying 91% of the average monthly premium while the state paid the remaining 9%. The figure below shows how the average monthly DPPO premium compares to the average monthly plan cost for Active employees and Retirees and their dependents (Active and Retiree members) in the DPPO plan.

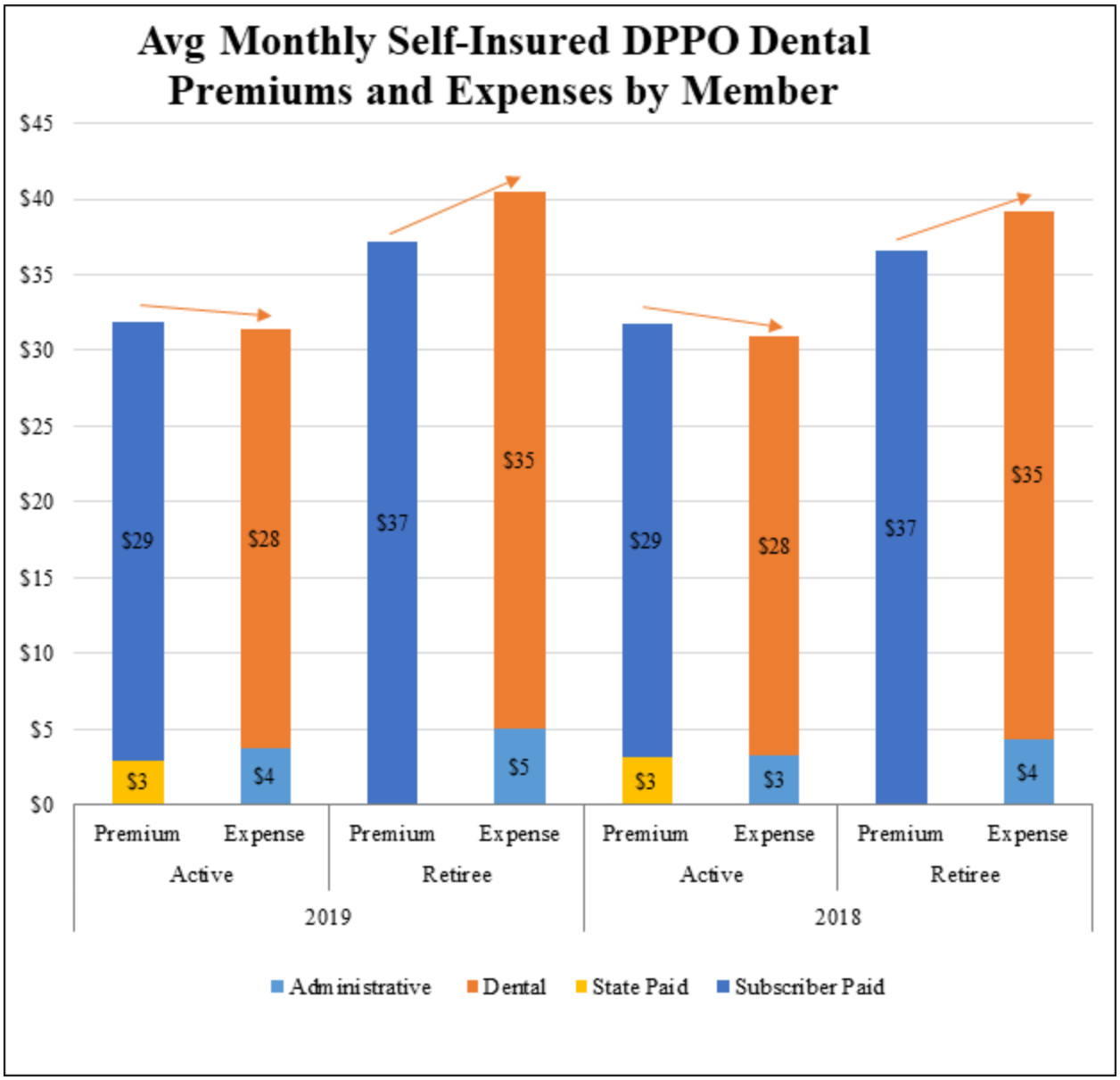


Figure 30: Average Monthly DPPO Dental Premiums and Expenses by Member

Expenses for Self-Insured Dental Plan

The figure below shows the distribution of claims and expenses incurred in PY 2019 and the average annual cost to insure each type of subscriber/member.

2019 Self-Insured Dental Expenses by Active, Retiree			
Expenses	**Overall**	**Active**	**Retiree**
Dental Claims	37,917,828	$27,518,221	$10,399,608
Rebates & Recoveries	$0	$0	$0
Administration Fees	$1,138,677	$801,165	$337,512
Operating Expenses & Adj.	$250,217	$176,051	$74,166
Total Expenses	**$39,306,722**	**$28,495,436**	**$10,811,286**
IBNR Liability	$3,845,000	$2,790,444	$1,054,556
Total	**$43,151,722**	**$31,285,880**	**$11,865,842**
Enrollment in self-funded plans			
Subscribers	51,877	36,500	15,377
Members	107,491	83,064	24,427
Annual cost			
Per subscriber	$832	$857	$772
Per member	$401	$377	$486

Figure 31: Self-Insured Dental Expenses by Active and Retiree

Wellness

The Benefit Services Division provides wellness programs and services to Active State employees. Members have access to preventive health screenings, health management and health education webinars and courses, annual flu vaccines, online lifestyle management programs, onsite seminars, activity challenges, and Employee Assistance Program (EAP) benefits.

The Health Impact Program (HIP) offers an incentive-based employee wellness program for benefits-eligible State of Arizona employees. For PY 2019, the program ran between January and December of 2019. The program offered a web portal to allow employees to engage in preventive services and healthy activities throughout the full year. The mission of the HIP is to promote prevention for early detection and defense against chronic disease, thereby encouraging employees to engage in health management programs to reduce risks, change behaviors that lead to healthy outcomes, and to foster greater total health and well-being.

Employees who successfully completed the program by engaging in a variety of wellness activities while accumulating and logging progress towards an end goal of 500 points were eligible to receive up to a $200 incentive payout, which was paid out in the spring of 2020.

Engagement and Incentives

The PY 2019 chart below shows that of the 60 thousand eligible members, there were 2,268 new employees enrolled in 2019 in addition to the 13,951 employees enrolled in 2018, totaling 16,219 or 27% of the eligible population. Of those that enrolled in the HIP program, 8,118 completed the online Health Assessment, which translates to a 50% completion rate, which is a slight increase over PY 2018.

The number of enrolled participants that actively logged was 10,451. Out of the 6,754 participants logging 500 points, 5,479 were validated and earned the $200 incentive for an estimated payout of $1,095,800 (34% of total enrolled). This represents an increase of 26% over PY 2018. Of total eligible employees, 11% earned the incentive.

By providing the HIP incentive component, the year over year participation metrics showed an increase in employee engagement and in overall active participation in preventive services, screening referrals, health assessment completion, and educational/behavior change and challenge activities.

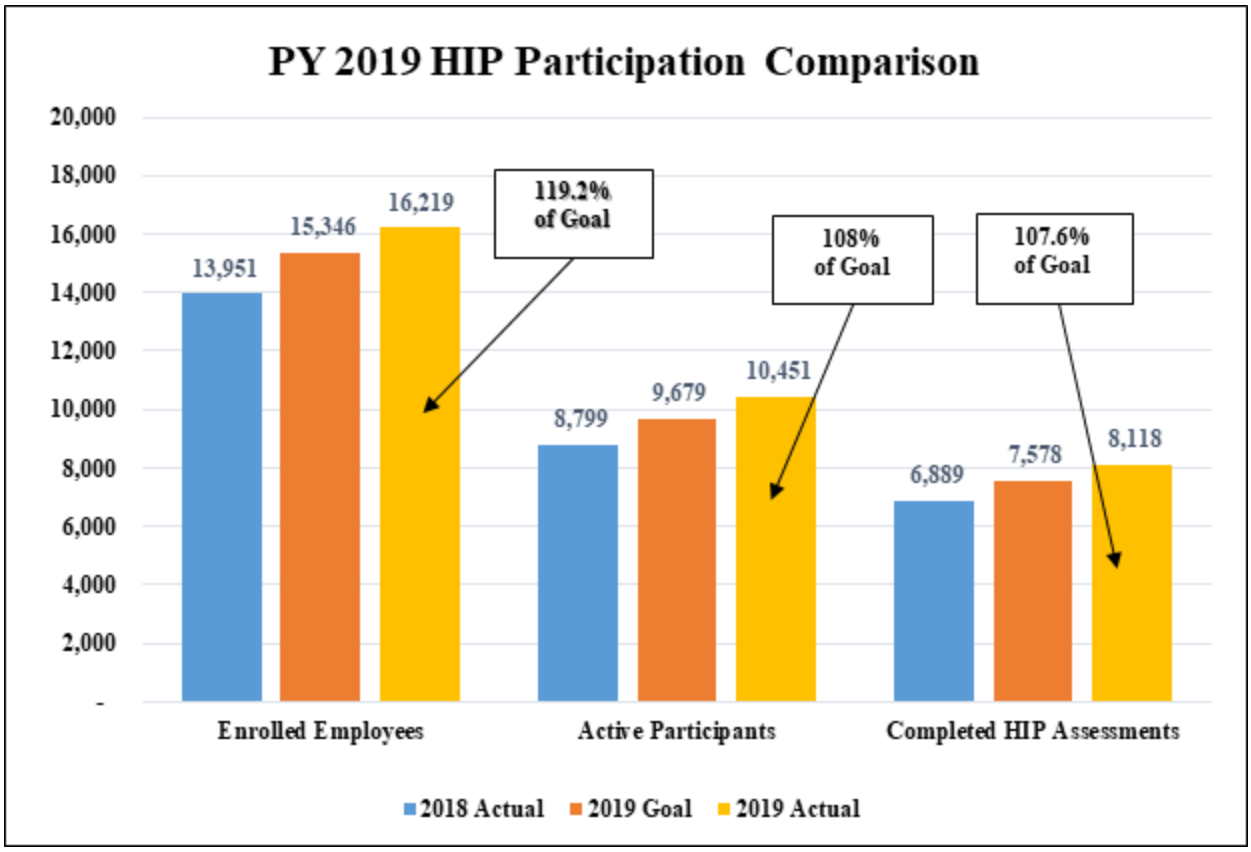


Figure 32: HIP Participation Comparison

Screening Utilization

The table below depicts the total utilization of core health screening benefits during PY 2019. The number of at-risk employees referred to follow-up care increased from 686 in PY 2018 to 773 referrals in PY 2019. ADOA continued the collaboration with the Arizona State University College of Health Solutions - Speech and Hearing Clinic to offer hearing screenings at five agency locations with 532 participants.

PY 2019 Health Screenings			
	Events	**Participants**	**Referrals**
Mini Health Screening*	131	4,280	
Osteoporosis Screening**		2,078	365
Prostate Specific Antigen (PSA)**		685	22
Hemoglobin A1C **		2,188	222
Hearing Screenings	5	532	50
Mobile Onsite Mammography	57	809	95
Prostate Onsite Projects	49	397	**19**
Total	**242**	**10,969**	**773**

**The base Mini Health Screening includes: full lipid panel, fasting blood glucose, blood pressure, and body composition measurements.*

*** Additional tests offered as a package with the basic Mini Health Screening for those meeting specific age requirements.*

Figure 33: Health Screenings

Flu Vaccine Program

The table below shows the total utilization for the PY 2019 State Wellness Annual Flu Vaccine Program held September 1, 2019 through December 31, 2019. 15,237 vaccines were administered to Active and Retiree members at 570 events held at various locations throughout the state. Close to 95% of members who received a flu vaccine, did so at a worksite or open enrollment clinic. The plan costs of the PY 2019 State Wellness Annual Flu Vaccine Program totaled $462.5K, which is an average of $30.3 per participant. In contrast, 33,892 members and their dependents received flu vaccines through the medical plans in PY 2019 at a cost of $763K with an average cost of $22.51 per participant.

PY 2019 Flu Vaccines		
	Locations	**Participants**
State Agency Worksite	199	6,679
University Worksite	35	5,853
Combined Worksite (Wesley Bolin)	3	915
Open Enrollment Clinics	14	1,052
Public Clinics	319	738
Total	**570**	**15,237**

Figure 34: Flu Vaccines

As per Passport Health USA (see link below), each year 5% to 20% of the U.S. population gets the flu. Adults 18-64 years of age accounted for almost 60% of reported flu hospitalizations. The result is lost employee productivity, an increase in absenteeism, and costly medical bills. Per the Passport Health USA portal calculator, the estimated medical savings are $3.2M. Taking into account the cost of administering the flu vaccines program of $462.5K and vaccines paid via medical vendors of $763K, the estimated medical net cost avoidance is $2.3M or an ROI close to 3:1. This calculation does not include the cost of absenteeism.

Employee Assistance Program

The table below shows the utilization for the Employee Assistance Program (EAP) and support services offered to agencies covered under the Benefit Services Division. The provider of EAP services is ComPsych, Inc., the world's largest provider of employee assistance programs servicing more than 45 thousand organizations and 100M individuals. The total EAP utilization rate for PY 2019 reached 45.8%, constituting an increase over PY 2018 utilization level of 40.1%. Utilization is indicating sustained high usage, especially when compared to the 24% national standard for government entities. Moreover, Benefit Services Division covered agencies also continue to show utilization higher than ComPsych's Book of Business. The PY 2019 contract includes up to 12 visits per issue per person/year. It also provides increased hours available for employee visits for those impacted by trauma or Post Traumatic Stress Disorder (PTSD).

PY 2019 EAP Utilization			
	Eligible Population	**Users**	**Utilization Rate**
Live Telephonic Access		**4,218**	
EAP		3,445	
FamilySource		120	
FinancialConnect		128	
LegalConnect		525	
Online Access		**6,579**	
EAP		2,416	
FamilySource		2,051	
FinancialConnect		1,012	
GlobalConnect		14	
Health & Wellness		933	
LegalConnect		153	
Critical Incident Stress Debriefing		**191**	
Trainings		**3,324**	
Overall Utilization	**37,153**	**14,312**	**38.5%**

Figure 35: EAP Utilization

In addition to health screenings, vaccines, and EAP services, the strategic plan for PY 2019 continued to provide employees with increased access to online mindfulness, stress reduction, and education by enhancing the options for participation and increasing the number of sessions offered monthly through ComPsych, Inc.

PY 2019 Webinars through ComPsych		
	Classes	**Participants**
1-hr Webinars	24	2,301

Figure 36: ComPsych Webinars

Weight and Diabetes Management Programs

To address the increasing health trends around weight and diabetes, four new programs were implemented to provide employees, spouses and dependents over the age of 18, with the support and tools necessary to improve health, experience positive outcomes, and achieve personal health goals.

Our program offers best in class, evidence-based approaches to address behavior change and prevention of chronic diseases like Type 2 diabetes, cardiovascular disease, and high blood pressure. They use clinically proven research along with engaging online or at work experiences to deliver sustainable lifestyle changes and healthy outcomes.

One such program, Real Appeal, is part of the medical plan and has shown significant engagement and results.

PY 2019 Real Appeal Metrics	
Enrolled Participants	2,244
Participants at Risk	87%
Participants with Weight Loss	914
Attended 4+ Sessions w/5% Weight loss	33.00 %
Average Weight Loss/year	3.20%
Total Pounds Lost	7,478

Figure 37: Real Appeal Metrics

Wellness/Lactation Rooms

In 2019, the ADOA was awarded Lactation grant funds from Maricopa County Department of Health Services to establish wellness/lactation rooms at the ADOA main building located at 100 N. 15th Avenue in Phoenix to provide a private, comfortable space for employees and visiting guests on official business. These rooms are designated for use by lactating mothers, parents with infants at work, individuals who need to rest when feeling ill, individuals who need to relieve stress or individuals with other special medical reasons or needs.

The grant funds directly support the recently approved Infant at Work program. Grant funds were used to cover the costs of the room set up, furniture, equipment, and materials.

Awards

The State of Arizona has been announced a Silver winner of the 15th-annual Health at Work Awards sponsored by ComPsych in September 2019, honoring organizations that promote employee health and wellness. Winners were selected based on their wellness program's comprehensiveness, innovation in delivery and promotion, participation rates, and results achieved. ComPsych Corporation is the world's largest provider of employee assistance programs and is the pioneer and worldwide leader of fully integrated EAP, behavioral health, wellness, work-life, human resources (HR), Family Medical Leave Act (FMLA), and absence management services under its GuidanceResources brand. The award does not apply to a specific period and covers both the 2018 and 2019 plan years.

Life, Disability, Vision Insurance and Flexible Spending Accounts

Fund 3035, ERE/Benefits Administration, is used to pay fully insured premiums and administer State employee benefit plans other than health and dental. These include basic, supplemental, and dependent life insurance, short-term, and non-ASRS long-term disability insurance, vision insurance, and medical and dependent care flexible spending accounts. Basic life and non-ASRS long term disability insurance are funded solely by State agency premiums (employer premiums) while all others are funded solely by employee premiums. Fund 3035 is primarily a pass-through fund with collections funding the premium payments. The table below is a cash statement of receipts received and expenses paid during PY 2019. It contains revenue and expenditures for PY 2019 incurred revenues and expenditures as well as for prior plan years. In PY 2019, the life and disability insurance services were provided by Hartford Life and Accident Insurance Company, while vision benefits were offered through Avesis Third Party Administrators, Inc. (Avesis) and dependent and flexible spending account services through Application Software, Inc. (ASIFlex).

ERE/Benefits Administration Fund Summary				
				Plan Year 2019
Beginning Fund Balance January 01, 2019				$1,893,610
Revenues				
Insurance Product	**Amount**			
Basic Life	$1,171,312			
Supplemental Life	8,369,195			
Dependent Life	2,853,762			
Short Term Disability	4,832,519			
Long Term Disability	3,769,690			
Total Life & Disability			$20,996,478	
Vision	5,651,222		5,651,222	
Health Care FSA	$6,847,327			
Dependent Care FSA	1,833,704			
Total Flex Spending			$8,681,031	
Total Revenues				$35,328,731
Expenditures				
Insurance Product	**Amount**	**Penalties**		
Basic Life	$1,160,792	-		
Supplemental Life	8,298,028	-		
Dependent Life	2,838,440	-		
Short Term Disability	4,798,531	-		
Long Term Disability	3,717,825	-		
Other Operating Costs	2,697	-		
Total Life & Disability*			$20,816,313	
Vision*	5,607,485	-	$5,607,485	
Health Care FSA	6,476,447	-		
Dependent Care FSA	1,715,064	-		
Administrative Fees*	221,067	-		
Imprest Deposit for New Vendor	338,500	-		
Other Operating Costs	1,315			
Total Flex Spending			$8,751,078	
Total Expenditures	$35,176,190	-		$35,176,190
Ending Fund Balance December 31, 2020				$2,046,152

*Vendor administrative fees and fully insured premiums are paid 55 days in arrears per contract.

Figure 38: ERE/Benefits Administration Fund 3035 Summary

Vendor Performance Standards

Pursuant to A.R.S. § 38-658(B), "On or before October 1 of each year, the Director of the Department of Administration shall report to the Joint Legislative Budget Committee on the performance standards for health plans, including indemnity health insurance, hospital and medical service plans, dental plans, and health maintenance organizations."

Among the terms of the self-insured health insurance contracts and other contracts the Benefit Services Division administers are several ADOA negotiated performance measures with specific financial guarantees tied to vendor performance of the contracted services. If a vendor fails to meet any of the measures within the specified performance range, the vendor is required to submit a Corrective Action Plan detailing why the measure was missed, and any actions taken to address the issue and improve performance to meet the standard of the measure. A percentage of the vendor's annual payment, or previously agreed upon amount, is then withheld by ADOA as a performance penalty per the terms of the vendor contract. This percentage is allocated among the more critical measures of the contract.

The following is a report of the agreed-upon performance standards, both met and missed, by contracted vendors during PY 2019. In each case, performance penalties for measures missed are assessed per the terms of the individual vendor contract. As some performance metrics are yet to be finalized, the estimated performance penalty paid to the Benefit Services Division related to PY 2019 will be approximately $532,031. Those performance measure penalties will be processed during PY 2020.

Aetna

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 190 Targets successfully met = 167 Targets missed resulting in penalties = 23 Targets Pending = 1	Approximately $83,954

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Appeals – At least 95% of urgent pre-service appeals are resolved within 15 calendar days of receipt; post-service appeals resolved within 30 days.	1.50% of Total Administrative Fee	Missed 4 of 12 months measured = 0.5%
Claims – Processing Turnaround Time: At least 98% of all fully-documented claims	1.00% of Total Administrative Fee	Missed 1 of 12 months measured = 0.08%

will be processed within 30 calendar days of receipt		
Claims – Financial Accuracy: At least 98% of claims dollars submitted for payment will be accurately processed and paid.	2.00% of Total Administrative Fee	Missed 1 of 12 months measured = 0.16%
Claims – Processing Accuracy: At least 98% of claims will be processed accurately	1.00% of Total Administrative Fee	Missed 3 of 12 months measured = 0.25%
Customer Service – Quality Member Phone Services: Aetna will provide phone service to members with no more than 3% abandonment rates and average speed to answer of 30 seconds or less.	1.50% of Total Administrative Fee	Missed 10 of 12 annual measurement = 1.25%
Account Management – Enrollment Processing: Aetna will process at least 98% of all enrollments within 2 business days of receipt of the file load.	1.00% of Total Administrative Fee	Missed 1 of 12 annual measurement = .083%
Reporting – Timeliness: Agreed upon reporting packages must be submitted within stated timeframes.	1.00% of Total Administrative Fee	Missed 1 of 12 annual measurement = .083%
HSA Administration – Quality Member Phone Services: Aetna will provide phone service to members with no more than a 30-second average speed to answer and no more than a 3% call abandonment rate.	3.00% of HSA Fees	Missed 1 of 12 annual measurement = .25%
Case Management and Disease Management Customer Service – Member Satisfaction: Aetna will obtain at least a 90% satisfaction rate on the annual member satisfaction survey conducted by ADOA.	1.00% of CM/DM Administrative Fee	Missed 1 of 12 annual measurement = .083%

Figure 39: Performance Measures – Aetna

Application Software, Inc. - ASI

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 49 Targets successfully met = 47 Targets missed resulting in penalties = 2	Approximately $2,763

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Program / Claim Administration – Claims Processing: All fully documented claims received will be processed within two business days.	2.50% of Total Administrative Fee	Missed 2 of 4 measured = 1.25%

Figure 40: Performance Measures – ASI

Avesis

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 182 Targets successfully met = 176 Targets missed resulting in penalties = 6	Approximately $188,374

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Account Management - Satisfaction Survey: Avesis will provide sufficient staffing levels and expertise to appropriately support the State's contract. This shall be determined by a yearly survey of State Management staff with an average of 90% of Management Staff satisfied with the staff.	1.00% of Total Administrative Fee	Missed 1 of 1 annual measurement = 1.00%
Customer Service - Answer Time: 90% of phone calls requesting a member services representative will be answered in 30 seconds or less.	1.00% of Total Administrative Fee	Missed 4 of 12 measured = 0.33%
Survey – Member Satisfaction: ADOA will perform a satisfaction survey of the vision plan at least annually. Avesis shall receive no less than 85% for overall member satisfaction on the annual survey.	2.00% of Total Administrative Fee	Missed 1 of 1 annual measurement = 2.00%

Figure 41: Performance Measures – Avesis

Blue Cross Blue Shield (BCBS) of Arizona

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 185 Targets missed resulting in penalties = 10 Targets Pending = 5	Approximately $33,780

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Financial Accuracy (Dollar Value) – Processing accuracy: At least 98% of claims dollars submitted for payment will be accurately processed and paid (financial accuracy will be based on an audit sample of ADOA specific claims).	1.00% of Total Administrative Fee	Missed 1 of 12 measured = 0.083%
Claims – Processing accuracy: At least 99% of all claims will be processed accurately	1.00% of Total Administrative Fee	Missed 4 of 12 measured = 0.33%
Reporting - Timeliness: Agreed upon reporting packages (identified on the Report Index) must be submitted within stated timeframes.	.50% of Total Administrative Fee	Missed 4 of 12 measured = 0.166%
Case Management and Disease Management – Quality Nurse Line Phone Services: BCBS will obtain at least a 90% satisfaction rate on the annual member satisfaction survey conducted by ADOA.	.50% of CM/DM Administrative Fee	Missed 1 of 1 annual measurement = 0.50%

Figure 42: Performance Measures – Blue Cross Blue Shield of Arizona

Cigna

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 181 Targets missed resulting in penalties = 14 Targets Pending = 5	Approximately $20,139

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Claims – Processing TAT: At least 99% of all fully documented claims will be processed within 30 calendar days of receipt.	1.33% of Total Administrative Fee	Missed 3 of 12 months measured = 0.3325%
Customer Service - Appeals - Accurate and timely response to member requests for review; urgent appeals resolved within three (3) business days of request, pre-service resolved within 15 calendar days of request, and post-service resolved within 30 calendar days of request.	0.75% of Total Administrative Fee	Missed 5 of 12 months measured = 0.3125%
Customer Service – Member Satisfaction Survey: Cigna will obtain at least a 90% satisfaction rate on the annual member satisfaction survey conducted by ADOA.	0.75% of Total Administrative Fee	Missed 1 of 1 annual measurement = 0.75%
Customer Service – Member Satisfaction Survey (Medical Management): Cigna will obtain at least a 90% satisfaction rate on the annual member satisfaction survey conducted by ADOA.	0.75% of Total Administrative Fee	Missed 1 of 1 annual measurement = 0.75%
Claims – Processing Accuracy: At least 99% of claims will be processed accurately.	1.34% of Total Administrative Fee	Missed 3 of 12 months measured = 0.335%
Reporting – Timely Reporting: Agreed upon reporting packages (identified on the Report Index) must be submitted within stated timeframes.	1% of Total Administrative Fee	Missed 1 of 12 months measured = 0.08%

Figure 43: Performance Measures – Cigna

Delta Dental

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 262 Targets successfully met = 262	No penalties

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
N/A	N/A	N/A

Figure 44: Performance Measures – Delta Dental

Cigna Dental

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 120 Targets successfully met = 118 Targets missed resulting in penalties = 2	Approximately $4,360

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Report Timeliness- Monthly Reporting: Monthly reports in required format received by ADOA within thirty (30) calendar days of the end of the month.	.67% of Total Administrative Fee	Missed 2 of 12 measured = 0.11%

Figure 45: Performance Measures – Cigna Dental

ComPsych

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 39 Targets successfully met = 38 Targets missed resulting in penalties = 1	Approximately $2,672

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Account Management/Customer Service-Abandonment Rate: Less than 3% of calls abandoned. This is a Customer Service metric for the Guidance Resources Unit (GRU) only.	3.00% of Total Administrative Fee	Missed 1 of 4 quarterly measured= .75%

Figure 46: Performance Measures – ComPsych

The Hartford

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 141 Targets successfully met = 138 Targets missed resulting in penalties = 3	Approximately $78,736

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
All Claims – Financial Accuracy: Financial Accuracy (Dollar Value): At least ninety-eight percent (98%) of claims dollars submitted for payment shall be accurately processed and paid (financial accuracy will be based on an audit sample of ADOA-specific claims).	1.00% of Total Administrative Fee	Missed 1 of 12 measured = 0.08%
STD Claims - Fully Documented TAT (5 Business Days): At least ninety-five percent (95%) of all fully documented STD claims shall be processed within five (5) business days of receipt. (Turnaround times will be based on an audit sample of ADOA-specific claims reported on ADOA specific basis.)	0.50% of Total Administrative Fee	Missed 1 of 12 measured = 0.04%

Customer Service - Member Satisfaction Survey: Hartford shall obtain at least an eighty-five percent (85%) satisfaction rate on its STD claims processing service in the annual member satisfaction survey conducted by ADOA.	.25% of Total Administrative Fee	Missed 1 of 1 annual measurement = .25%

Figure 47: Performance Measures – The Hartford

MedImpact

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 109 Targets successfully met = 99 Targets missed resulting in penalties = 10	Approximately $117,250

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Survey – Customer Satisfaction: At least 90% are satisfied with the retail program.	$70,000 annual amount at risk	Missed 1 of 1 annual measurement = $70,000
Generic Substitution / Utilization – Mail Service: At least 97% of total mail service prescriptions with available generics shall be dispensed with a generic product.	$25,000 quarterly	Missed 4 of 4 quarterly measurements = $25,000
EGWP - Payment Remittance: Upon receipt, monthly payments from CMS shall be remitted to ADOA by ACH within the first 10 business days each month.	$16,000 quarterly	Missed 1 of 4 quarterly measurements = $6,000
EGWP – Grievance Resolution: 100% of member grievances shall be resolved within CMS timelines.	$16,000 quarterly	Missed 3 of 4 quarterly measurements = $12,000
Generic Substitution / Utilization – Utilization Increase: Guaranteed percentage increase in generic utilization on a plan year basis. At least 1.0% annual increase in generic utilization.	$25,000 quarterly	Missed 1 of 4 quarterly measurements = $6,250

Figure 48: Performance Measures – MedImpact

Telligen

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 50 Targets successfully met = 50 Targets missed resulting in penalties = 0	No penalties

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
N/A	N/A	N/A

Figure 49: Performance Measures – Telligen

UnitedHealthcare

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 195 Targets missed resulting in penalties = 0 Targets Pending = 5	No Penalties

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
N/A	N/A	N/A

Figure 50: Performance Measures – UnitedHealthcare

Audit Services

The Benefit Services Division-Audit Services Unit provides assurances that add value and improve the operations of Benefit Services. Audit Services performs systematic evaluations of contract compliance, operational controls, risk management, and the implementation of best practices to support BSD objectives.

The audit schedule for the 2019 Plan Year was developed using a combination of contract elements and risk analysis. An overview of the completed project results for the 2019 plan year is shown below. This includes recommendations made, implemented recommendations, identified savings, and health plan recovery dollars. During PY 2019, four audit projects were completed to ensure the health plan vendors appropriately provided contracted services. Two completed audit projects for the 2019 plan year identified no exceptions or dollars for recovery with two recommendations to be implemented. One audit identified $5,280.21 in savings to the Plan and three recommendations in the process of implementation. One audit is in process and will be completed in the 2020 Plan Year.

The reporting year for implementation of recommendations and health plan recoveries for completed audits will vary based on the vendor's completion date of all corrective action plan directives. The directives include vendor impact reports to determine pending recovery dollars (amounts will be greater than the savings identified during the audit due to scope period limitations). In many cases, directives are still in progress and may roll over to a new plan year. Recoveries are based on the completion of a corrective action plan that includes impact reports to identify affected claims and dollar error amounts, claims reprocessing/adjustments, and/or payments directly from the vendor.

Recommendations	Implemented Recommendations	Identified Savings	Recovery Dollars	Pending Recovery
5	1	$5,280	0	$5,280

Figure 51: Audit Recommendation Implementation and Recoveries Summary

Individual audit objectives were developed with the consideration of dollar value, complexity of operations, changes in personnel or operations, loss exposure, and previous audit results. Audits and other projects were completed, and were not limited to the following functional areas:

Functional Area	Audit Methodology
Vendor operating transactions and controls	Statement on Standards for Attestation Engagements No. 18 Audits (SSAE 18) Evaluation of external audit results
Vendor execution of benefit design and contract elements	End-Stage Renal Disease – claims adjudication compliance Inquiries (e.g., research, plan coverage design, etc.)

Accuracy/use of shared data	Migration of digital documentation to Google cloud drive Health Reporting Information System upgrade testing
Audit program improvement initiatives	Vendor electronic claims data file revisions Administrative functions and program-specific improvements

Figure 52: Audit Functional Area and Methodology

Vendor Operating Transactions

All health plan contracted vendors that pay claims are required to provide a copy of a SSAE 18, which is an independently assessed operational annual or semi-annual audit. SSAE 18 audits evaluate the internal controls of the vendor's systems utilized to process claims and identify deficiencies. Audit services reviewed the SSAE 18 reports provided by each of the vendor's external auditors. There were no instances of significant operating failure noted and no corrective action was required by Audit Services. In addition, audits performed by external or third party vendors are evaluated and considered for the development of the audit schedule when there is a significant impact on the health plan and contract compliance.

Vendor Execution of Benefit Design and Contract Elements

Claims adjudication compliance audits are performed to evaluate the contracted vendors' adherence to regulatory guidelines, healthcare industry standards, current operating standards, contractual elements, vendor performance, and/or plan authorization documents. During the 2019 plan year, an End-Stage Renal Disease (ESRD) Audit of the medical vendors' accuracy of primary and secondary payer status was conducted. For the three contracted vendors completed in 2019, the audit identified $5,280.21 of recoverable savings. The fourth contracted vendor audit was in process and findings were not yet determined.

Various internal inquiries were researched and completed to support the functions of the Benefit Services Division. A response to an inquiry can be informal and/or open a formal audit based on significant findings of the evaluation. An exception-based audit is an evaluation response to a customer complaint or an identified process failure. Exceptions are generally categorized as operational weakness or claims payment errors. In both instances, audits are developed with a very limited scope to address the specific identified exception. There were no additional exception-based audits performed during the 2019 plan year.

Accuracy/Use of Shared Data

The Arizona Department of Administration (ADOA) is leading a statewide initiative to migrate data from the State's internal servers to the Google cloud-based platform. Migrating to the cloud will improve document security, retrieval, and collaboration capabilities. The Audit team provided support in 2019 as the Benefit Services Division's project lead and Library Administrator. Audit Services assisted in the performance of user acceptance testing for the Human Resources Information System. Testing was completed to support a system upgrade.

Audit Program Improvement Initiatives

As new contracted vendors were chosen to administer benefits to the State employees and retirees effective January 1, 2021 (PY 2021) via a Request for Proposal in PY 2020, Audit

Services revised the necessary requirements to submit claims payment data electronically to ADOA. Claim file revisions were made to comply with industry and ADOA standards, add missing data fields, clearly define and normalize data across contracted vendors, and to provide ease of data interpretation for audits, budget and actual expense calculations, and financial metrics.

In addition to the regularly scheduled audits, reviews, and evaluations listed above, Audit Services continued assisting in the performance of user acceptance testing and issue resolution for a recently implemented claims data warehouse tool used to report and track health plan data metrics.

Audit Services, in conjunction with the Finance team, continued to explore potential fraud, waste, and abuse (FWA) in the Benefit Options Health Plan. The audit team completed three projects with recommendations made, quality issues identified, and health plan savings/recovery of dollars.

Audit Services continues to strive towards improvement and efficiency; the focus during the PY 2019 was to streamline administrative functions to improve audit program initiatives.

Appendix

Special Employee Health Fund Cash Flow Statement

Special Employee Health Fund Cash Statement

Plan Year 2019

Beginning Fund Balance January 01, 2019				**$109,909,504**
Revenues				
Source	**Premiums**			
ADOA Health Plan (EE)	$146,751,262			
ADOA Health Plan (ER)	634,593,286			
BCBS NAU Plan (EE)	8,893,550			
BCBS NAU Plan (ER)	32,515,608			
ADOA Dental Plan (EE)	28,788,548			
ADOA Dental Plan (ER)	13,847,029			
PrePaid Dental Plan (EE)	1,593,886			
PrePaid Dental Plan (ER)	2,310,783			
Other Revenue	49,301			
Net Revenue	**$869,343,252**			**$869,343,252**
Expenditures				
Vendor	**Admin Fees & Other Ins. Related Charges**	**Penalties**		
Aetna	4,222,149	-		
Blue Cross Blue Shield AZ	7,555,038	(21,304)		
Cigna	2,448,056	-		
UnitedHealthcare	11,998,222	(8,424)		
MedImpact	1,295,913	-		
HSA Funding (EE and ER)	10,330	-		
Delta Dental	1,138,677	-		
HIP Payout	855,016	-		
ACA Related Taxes/Fees	268,625	-		
AG Collection Fees	12,207	-		
Net Administrative Fees*	29,804,233	(29,728)	29,774,505	
	Claims	**Recoveries****		
Aetna	66,421,446	-		
AmeriBen	-	(5,321) ****		
Blue Cross Blue Shield AZ	159,143,599	(352,676)		
Cigna	50,715,781	(18,173)		
UnitedHealthcare	325,021,522	(351,786)		
MedImpact	167,962,016	(16,195,924)		
Medicare Part D Retiree Drug Subsidy	29,882,784	(6,220,577)		
Delta Dental	38,359,380	-		
Other Wellness	725,065	-		
Net Claims	838,231,592	(23,144,458)	815,087,134	
Self-Insured Expenditures	**868,035,825**	**(23,174,186)**	**$844,861,640**	
	Premiums	**Penalties**		
BCBS (NAU Only)	41,468,516	-		
Cigna Dental, Total Dental Administrators	3,877,304	-		
Fully Insured Expenditures	**45,345,820**	**$0**	**45,345,820**	
HITF Operating	$5,349,487	-		
Fund Transfers Out***	2,636	-		
Administrative/Cash Adjustments	44,913	-		
Operating Expenes and Transfers	**$5,397,035**	**$0**	**$5,397,035**	
Net Expenditures and Transfers	**$918,778,680**	**($23,174,186)**		**$895,604,494**
Ending Fund Balance December 31, 2019				**$83,648,262**

* Vendor administrative fees and fully insured premiums are paid 55 days in arrears per contract

** Recoveries include Medicare Part D Retiree Drug Subsidy reimbursement, prescription drug rebates, overpayment recoveries (including stop payments and voids), claims audit recoveries and subrogation recoveries.

*** Fund transfers from HITF to other State funds.

Figure 53: Special Employee Health Fund Cash Statement

Glossary of Terms

Active member(s) – An employee and their eligible dependents, as defined in the Arizona Administrative Code, who are enrolled in one of the health plan options offered by the State. (Also referred to as "Actives".)

Administrative fees – Fees paid to third-party vendors for plan administration, network rental, transplant network access fees, shared savings for negotiated discounted rates with other providers, COBRA administration, direct pay billing, additional reporting billing, State fees (MA, MI and NY), and bank reconciliation fees.

Brand-name drug - Prescription drugs are drugs that are marketed with a specific brand name by the company that manufactures it, usually the company that develops and patents it. When patents run out, generic versions of many popular drugs are marketed at lower cost by other companies. Under our Plan, these drugs can also be referred to as Tier 2 drugs.

Case management – A collaborative process that facilitates recommended treatment plans to ensure that appropriate medical care is provided to disabled, ill, or injured individuals.

Claim – A provider's demand upon the payer for payment for medical services or products.

Claim appeal – A request by an insured member for a review of the denial of coverage for a specific medical procedure contemplated or performed.

COBRA, Consolidated Omnibus Budget Reconciliation Act of 1985 – A federal law that requires an employer to allow eligible employees, Retirees, and their dependents to continue their health coverage after they have terminated their employment or are no longer eligible for the health plan. COBRA enrollees must pay the total premium, in addition to an administrative fee of 2%.

Contribution strategy – A premium structure that includes both the employer's financial contribution and the employee's financial contribution towards the total plan cost.

Copayment – A form of medical cost-sharing in the health plan that requires the member to pay a fixed dollar amount for a medical service or prescription.

Deductible – A fixed dollar amount that a member pays during the plan year before the health plan starts to make payments for covered medical services.

Dependent – A child or a spouse of the employee who meets the conditions established by the relevant plan description.

Dental Health Maintenance Organization (DHMO) – A dental plan that offers members dental services with no annual maximums or claim forms, and services based on a discounted rate. Cigna Dental was the PY 2018 DHMO dental vendor.

Dental Preferred Provider Organization (DPPO) – A dental plan, with an in-network and out-of-network coinsurance structure, that allows members to visit any dentist. There is an annual deductible, and maximum annual benefit of $2,000 per member per year for dental services. The current administrator for the DPPO plan is Delta Dental.

Disease management – A comprehensive, ongoing, and coordinated approach to achieving desired outcomes for a population of patients. These outcomes include improving members' clinical conditions and qualities of life as well as reducing unnecessary healthcare costs. These objectives require rigorous, protocol-based, clinical management in conjunction with intensive patient education, coaching, and monitoring.

Eligibility appeal – The process for a member to request a review of a health plan decision regarding a claimant's qualifications for, or entitlement to, benefits under a plan.

Employee – As defined in the Arizona Administrative Code, a person who works for the State of Arizona or a State university.

Employer Group Waiver Program (EGWP) – An employer group Medicare Prescription D drug plan.

Exclusive Provider Organization (EPO) – A health plan designed with an exclusive provider organization or network. Enrollees are limited to access in-network providers and are subject to co-pays. Any exceptions require prior authorization.

Flexible Spending Account (FSA) – An account that can be set up through the State's Benefit Options program, an FSA allows an employee to set aside a portion of his/her earnings to pay for qualified medical and dependent care expenses. Money deducted from an employee's pay and put into an FSA is not subject to payroll taxes.

Formulary – A list of preferred medications covered by the health plan. The list contains generic and brand name drugs. The most cost-effective brand-name drugs are placed in the "preferred" category, and all other brand-name drugs are placed in the "non-preferred" category.

Fully Insured – An insurance model wherein a commercial insurer collects premiums, pays claims for services, and takes the risk of revenue to expense. Benefit Options may collect the premiums for transfer to the commercial insurer.

Generic Drug –A drug product that is comparable to a brand/reference listed drug product in dosage form, strength, method of administration, quality and performance characteristics, and intended use. The major difference between a generic drug and brand name drug is the price. Most generic drugs cost an average of 70% to 90% less than brand name drugs. Generic drugs are often sold under the chemical name of the drug. Under our Plan, generic drugs can also be referred to as Tier 1 drugs.

High Deductible Health Plan (HDHP) – A health plan designed with an open-access provider organization or network. Enrollees have access to in-network and out-of-network providers, and are subject to coinsurance and higher annual deductibles than traditional plans. Out-of-network providers require greater coinsurance.

Health Savings Account (HSA) – An account that allows individuals to pay for current health expenses and save for future health expenses on a tax-free basis. Only high deductible health plans are HSA-eligible.

Inpatient admissions per 1,000 members – The number of hospital admissions for every 1,000 members. An admission can be more than one day.

Integrated – A health plan operation administered by one entity. Such operations include claims processing and payment, a network of medical providers, utilization management, case management, and disease management services.

Medicare – The federal health insurance program provided to those who are age 65 and older or those with disabilities, who are eligible for Social Security benefits. Medicare has four parts: Part A, which covers hospitalization; Part B, which covers physicians and medical providers; Part C, which expands the availability of managed care arrangements for Medicare recipients; and Part D, which provides a prescription drug benefit. Retirees signing up for ADOA insurance must enroll in Parts A and B, but not C or D.

Member – A health plan participant. This individual can be an eligible employee, Retiree, spouse, or dependent.

Network – An organization that contracts with providers (hospitals, physicians, and other healthcare professionals) to provide health care services to members. Contract terms include agreed-upon fee arrangements for services and performance standards.

Per Member Per Month (PMPM) – Refers to the average cost per member per month. The PMPM is calculated by dividing the total paid claims for a particular month by the number of members covered that month or by taking the total annual costs divided by average monthly membership divided by twelve (months).

Payer – The entity responsible for paying a claim.

Pharmacy Benefit Manager (PBM) – An organization that provides a pharmacy network, processes and pays for all pharmacy claims, and negotiates discounts on medicines directly from the pharmaceutical manufacturers. These discounts are passed to the employer/payer in the form of rebates and reduced costs in the formulary.

Plan Year (PY) – Defined as the period of January 1 through December 31 of a given year.

Preferred Provider Organization (PPO) – A health plan designed with a preferred provider organization or network. Enrollees have access to in-network and out-of-network providers, and are subject to copayments, or coinsurance, and annual deductibles. Out-of-network providers require greater copays.

Premium – The agreed-upon fees paid for medical insurance coverage. Both the employer and the health plan member pay premiums.

Retiree – A former State of Arizona employee, State university employee, officer, or elected official who is retired under a State-sponsored retirement plan. For reporting purposes, this term encompasses both actual Retirees and their dependents.

Self-funded – An insurance program wherein Benefit Options collects premiums, pays claims, and assumes the risk of revenues to expenses.

Self-insured – A plan that is funded by the employer who is financially responsible for all medical claims and administrative expenses.

Spouse – A dependent legally married to an employee or a Retiree, as defined by the Arizona Revised Statutes.

Subscriber – An employee, officer, elected official, or Retiree who is eligible and enrolls in the health plan.

Third-party administrator – An organization that handles all administrative functions of a health plan including processing and paying claims, compiling and producing management reports, and providing customer service.

Utilization management – The evaluation of appropriateness and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan.

Utilization review – A process whereby an insurer evaluates the appropriateness, necessity, and cost of services provided.

Utilizer – A member who receives a specific service.